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INVENTORY

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A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

Published By THE N. C. ALCOHOLIC REHABILITATION PROGRAM

Vol. I MAY, 1951 No. 1

TREATMENT REHABILITATION EDUCATION PREVENTION

INVENTORY
A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

VOL. 1 No. 1
MAY, 1951
RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the N. C. Alcoholic Rehabilitation Program at 357 Revenue Annex Building, Raleigh, N. C. Subscription price 50 cents per year.

S. K. PROCTOR.....*Executive Director, ARP*

SANTFORD MARTIN, JR.....*Editor - Educational Director*

APPLICATION FOR SECOND-CLASS ENTRY PENDING AT POST OFFICE, RALEIGH, N. C.

INVENTORY—A NECESSITY

If we are to understand the illness of alcoholism, we must take an inventory of what we know and don't know about beverage alcohol and human personality.

Honest inventory should produce an educational approach with four aims: to give scientific facts about alcohol and its problems, to eliminate prejudices that color the problems, to present alcoholism as an illness, to teach personal responsibility in all alcohol matters.

A recognized step in arresting alcoholism is the personal inventory a problem drinker finally takes of himself, led by his physician, often by Alcoholics Anonymous or a minister, occasionally by his family or a close friend. The drama of excuses is at first a painful ordeal, until the fog of alcoholism gives way to the truth.

That's what it takes, according to those who know, a fearless inventory down to the roots of the sufferer's personality—psychological, physiological, sociological, spiritual probing—a human, sympathetic but firm inventory of all faults and virtues.

Perhaps society would do well to take an inventory of its own collective personality, analyzing its traditional attitudes plus or versus its current actions. In contrast to the 5% considered curable only yesteryear, today's pioneer alcoholic clinics report 60 to 80% arrested cases.

This journal will present latest alcohol facts compiled by the Yale Laboratory of Applied Physiology, international authority on alcohol problems. It will feature developments in North Carolina's program, news and views of interested state-wide groups, and pertinent rehabilitation items over the nation.

Through INVENTORY, we hope every interested person will find adequate materials for taking stock of what he knows and doesn't know about this health problem.

THE EDITOR

A New Approach To An Old Problem

The illness of alcoholism is not a new problem in our society. We have had the problem as long as we have had the Commonwealth, but society today is seeking a new approach to this ageless problem.

In issuing this Journal on alcohol and alcoholism, the North Carolina Alcoholic Rehabilitation Program takes a pioneer step toward giving unbiased, scientific facts on this problem to those citizens who want such facts.

As I understand it, the Journal will handle a variety of stories and studies for general and specialized readers alike. This is a major step toward a fuller understanding of alcohol and the illness of alcoholism, toward ultimate prevention of such illness through treatment, rehabilitation, education.

W. KERR SCOTT
Governor of North Carolina

We hope that this first issue of INVENTORY will be the forerunner of many, serving a very important purpose in communicating and in spreading information about the Alcoholic Rehabilitation Program among the many persons interested in it.

We believe that communication will help a great deal in making our separate efforts more effective, but this means should also provide better knowledge and acquaintance where distance prevents frequent meetings which would be possible if we all lived in a small community.

We hope that there will be many contributions of activities and efforts in different parts of the State, and this publication will serve a very useful purpose.

DAVID A. YOUNG, M. D.
General Superintendent
North Carolina Hospitals Board
of Control

We of the North Carolina Alcoholic Rehabilitation Program have a great responsibility to the citizens of our state in acquainting them with alcoholism as an illness complicated by psychological, physiological, sociological, spiritual, and economic manifestations that present major health and welfare problems. Such responsibility demands fearless realism.

The journal, INVENTORY, will serve as an informational organ through which to acquaint our people with the latest facts on alcohol and alcoholism and the monthly progress of our alcoholic rehabilitation team. We like to think of this team consisting of the physician and the psychologist, the minister and Alcoholics Anonymous, the social case worker and the sociologist.

S. K. PROCTOR
Executive Director, ARP

A PIONEER REPORT

Faced With Opportunity

BY JOHN S. RUGGLES

To properly consider the problem of alcoholism, we must first accept three simple concepts. They are as follows:

1. Alcoholism is a disease and the alcoholic a sick person.
2. The alcoholic can be helped and is worth helping.
3. Alcoholism is a public health problem and, therefore, a public responsibility.

According to the North Carolina Vital Statistics records, deaths from alcoholism in 1948 equaled the deaths from appendicitis. Considering deaths attributed to other causes, but yet which were directly caused by alcoholism, such as pneumonia, accident, heart, etc. the death rate from alcoholism would undoubtedly lead all others.

Tar Heel Estimates

Based on Zelnick's studies, North Carolina has approximately 12,000 chronic alcoholics, and in addition there are countless more problem drinkers or potential alcoholics. These staggering figures definitely establish alcoholism as a major health problem.

As chairman of the Alcoholic Committee of the North Carolina Hospitals Board of Control, and with the approval of Dr. H. O. Lineberger, Chairman of the North Carolina Hospitals Board of Control, and Dr. David Young, General Superintendent of the North Carolina State Hospitals, I visited Virginia, New York, and Connecticut to investigate facilities for the care and treatment of alcoholics.

At a three day Southeastern Assembly of Alcoholics Anonymous in Richmond, Virginia, I attended a Hospitalization Forum, presided over by Dr. S. E. Hugh, Jr., of Downey, Illinois, the principal speakers being Dr. Ebbe Curtis Hoff, Medical Director, Division of Alcoholic Studies and Rehabilitation, Virginia State Department of Health, on the subject "Virginia's Alcoholic Clinic", and Dr. G. H. Gehrmann, Medical Director of E. I. duPont de Nemours & Company, on the subject "Industry Looks at A.A."

Personal Conferences, Leading Facilities

In addition, I attended six other meetings, heard talks by seventeen speakers and conferred personally with many of the six hundred alcoholics present from twenty states.

I also visited the Virginia Alcoholic Clinic and had a personal conference with its Director, Dr. Ebbe Curtis Hoff, and, in additon, had several conferences with Mr. James E. Gardner, Chief Patron of Virginia's Alcoholic Legislation.

In New York, I visited the following facilities for the care and treatment of Alcoholics: Knickerbocker Hospital, Manhattan; Charles B. Towne Hospital, Manhattan; St. Johns Hospital, Brooklyn; and Kings County Hospital, Brooklyn.

I also had one or more personal conferences with the following persons interested in the problem of alcoholism: Mr. Normon Brock, Chairman Alcoholic Division of Knickerbocker Hospital; Col. Edward B. Townes, Director Townes Hospital; Dr. William D. Silkworth, Medical Director of Knickerbocker & Townes Hospitals; Dr. Sam Parker, Medical Director Kings County Hospital; and Dr. Yvelin Gardner, Associate Executive Director National Committee for Education on Alcoholism.

I was also privileged to hear an outstanding address on alcoholism by Dr. Cornelius Beukenkamp, Senior Psychologist at Rockledge State Hospital (N.Y.) and consulting Psychiatrist at Flowers Fifth Avenue Hospital. His address was followed by a question period of much interest.

Contacts With Alcoholics Anonymous

In addition, I conferred with various persons of the Alcoholic Foundation and New York Intergroup Association of Alcoholics Anonymous and attended five meetings of Alcoholics Anonymous in New York, Brooklyn, and Long Island, hearing 15 speakers and con-

THE fact that alcoholism is a disease is not a new discovery. A scientific treatise defining alcoholism as a disease, and discussing methods of treating it, was written by a physician named Thomas Trotter in 1778, for which he was awarded a gold medal by the British Humanitarian Society.

A report on "Alcoholism, The Disease, and Its Treatment", was made by the Connecticut Medical Society in 1830, and the legislature was urged to establish special facilities for the treatment of alcoholics. Many other papers have been written on the same subject, and yet the conception of alcoholism as a disease is still news to many. INVENTORY, this pioneer journal on alcohol and alcoholism in North Carolina, should make such news a reality.

JOHN S. RUGGLES
Chairman, Alcoholic Committee
N. C. Hospitals Board of Control

ferring personally with many of the more than three thousand persons in attendance at these meetings.

I also visited the following persons noted for their activities in connection with the problem of alcoholism: Dr. Georgia Lolli, Medical Director of the Yale Plan Clinic, New Haven, Connecticut; Mr. Raymond G. McCarthy, Executive Director of the Yale Plan Clinic, New Haven, Conn.; and Mr. Dudley Porter Miller, PhD., Executive Director of the Connecticut Commission on Alcoholism, New Haven, Connecticut.

All of the persons visited in Virginia, New York, and Connecticut were most considerate in giving their time and counsel, and offered their continued services to the North Carolina Hospitals Board to the fullest extent in carrying out our program.

A Tremendous Responsibility

From my investigation to date, I have only begun to realize the magnitude of the problem of this committee, and our tremendous responsibility in attempting to carry out the directive of the legislature to provide facilities for the care and treatment of alcoholics.

Therefore, I recommend: THAT the Alcoholic Committee be authorized, with approval of the Chairman of the Hospitals Board, to immediately employ a full time Executive Director for the Alcoholic Committee, and such other personnel as may be required.

The Executive Director must be of such caliber that he can deal successfully with top level business and professional men. He must be thoroughly grounded in the problem of alcoholism, visiting and studying the facilities for the care and treatment of alcoholics in various states.

Four Major Steps

I further recommend we then proceed as follows:

FIRST, that we provide an intensive educational program on alcoholism throughout the state, through various means, as previously tested in numerous other states.

SECOND, that we authorize a study and survey of North Carolina's Alcoholic Problem.

THIRD, that we establish by delegation of operation, small alcoholic facilities in various local hospitals, with the cooperation of local medical groups, Civic and Welfare Agencies, Alcoholics Anonymous, and others.

FOURTH, that we establish a separate Alcoholic Rehabilitation Center at Camp Butner, for the care and treatment of those requiring additional care.

An Opportunity, A Pattern

North Carolina has not followed the approach to the Alcoholic Problem recommended by the National Committee for Education on Alcoholism. They suggest that initially no attempt be made to obtain general legislation involving the appropriation of a large sum of money for the treatment and rehabilitation of the alcoholic until after the appointment of a commission independent of any state department or agency, which would make a survey and study of the problem of alcoholism in the state, the existing methods and facilities for treatment, and the present program. Thereafter, the commission would make a report of its findings and recommendations, and ample funds would then be appropriated.

We are, therefore, faced with an opportunity to pioneer in the field of alcoholism, as a pattern for others to follow, or, failing to act, or acting unwisely, we may retard the approach to the alcoholic problem through state legislation in North Carolina and throughout the nation for years to come.

THE RANDOM TWINS

THE HAPPY MAN

The happiest man is the common everyday chap who makes his own living, pays his own bills, has a little money as he goes along but doesn't strive to get a corner on the local output, and is a slave neither to ambition nor society. He loves his God and his fellowman, knows "there's no place like home," believes in live-and-let-live, and when he encounters the needy, he doesn't stutter with his pocketbook. He is happy to be satisfied and does not spend the best years of his life yearning for things four sizes too large for him.

THE HARDEST STEP

A great deal of talent is lost in the world for want of a little courage. Every day sends to their graves obscure men whom timidity prevented from making a first effort and who, if they could have been induced to begin, would in all probability have gone great lengths in the career of fame.

The fact is, that to do anything worth while in the world, we must not stand back shivering and thinking of the cold and danger, but we must jump in and scramble through as well as we can.

NO FACET NEGLECTED

REHABILITATION—
The Team, The Process

By S. K. PROCTOR
Executive Director
N. C. Alcoholic Rehabilitation Program

When the director came into this work, he was given a copy of the report of the Alcoholic Committee which contained specific recommendations for establishment of a treatment center, a survey of North Carolina's alcoholic problem, education on alcoholism, and encouragement of local care facilities. These recommendations have been our guide.

Since emphasis was strongest for an in-patient treatment unit at Butner, our attention was directed there first. The old headquarters building was remodeled to provide attractive, clean and safe quarters for the housing of the patients. Complete renovation was required for new floors, ceilings, windows, screens, stairways, radiators, sprinkler system and interior walls.

The Doors Were Opened

Dr. Lorant Forizs was appointed Medical Director of the Alcoholic Unit. Other necessary personnel was assigned by Dr. James Murdoch, and arrangements for maintenance, laundry, and dietary requirements were completed with the Business Manager at Butner. On September 1, the doors were opened for the admission of the first patient, and by the last of April 228 patients had been admitted to the treatment center.

For admission, our patients bring with them or send ahead a social history providing our doctor with a summary of the patient's family, educational and vocational background. This social history is a necessity before the doctor can fully understand his patient, arrive at a diagnosis, and direct the patient toward sobriety and a fuller life.

The Social History, A Necessity

The social history is a detailed piece of work requiring the services of a well-trained and experienced person to prepare it. For experienced people in preparing these histories, we approached the Department

of Welfare to enlist their aid. This aid was immediately made available and each of the County Welfare Departments has been supplied with instructions to aid them in preparing these histories.

Treatment, at the present time, consists of group therapy discussions led by Dr. Forizs, the use of educational training films, individual consultations with the doctor, recreation, occupational therapy, rest, good food, and plenty of it, and medications as prescribed by the physician. Upon their discharge, our patients are referred to their family physician, nearest Mental Hygiene Clinic, and local AA group.

Follow up for our discharge patients presents one of the more complicated problems we have before us. Since our unit is set up for voluntary admissions, our patients must be accorded the same privacy they might expect from any other hospital for any other illness. Their medical history and charts are confidential and the information in these records cannot be disclosed except to another physician who might be attending the patient.

Contacts With Patients, Physicians

This means that we cannot use the services of public or private case work agencies in contacting discharged patients and in reporting their progress and condition to us. We can write to these discharged patients and the physician who aided them in gaining admission to the center, asking them to supply us with information relative to their condition and progress. This we are doing.

Notation is made on a card in our office of the questionnaires sent and those returned. A recap is made of the information, then the questionnaires are placed in the patient's file at Butner to become a part of his chart.

Current plans are to add a social worker to the Butner Treatment Center to assist Dr. Forizs in some of the group therapy, expand the social histories and obtain further help for the patient in securing the services of Employment Security and Vocational Rehabilitation.

Value Of Out-Patient Clinics

In-patient care is only one part of the rehabilitative process and alone cannot be depended upon to achieve lasting recovery from alcoholism. It is imperative that further care be available to patients upon their discharge and return to their homes. This knowledge has led us to direct some of our attention toward the establishment of out-patient clinics for alcoholics.

These clinics can serve those patients being discharged from the Butner Center, and act as a diagnostic and referral center for those people who may be directed to the clinics from other sources.

Since the personnel requirements of an alcoholic center are essentially the same as those of mental hygiene clinics and some federal and state funds are available for these clinics, we are trying to arrange working agreements with these clinics to serve alcoholic patients as well as non-alcoholic patients. Before this can be done, the existing clinics must be sufficiently staffed to meet their present requirements and case loads.

We then must supply them with the services of a trained psychiatric social worker to meet the additional case load of alcoholic patients. This may seem simple enough except that in the clinics in Asheville, Charlotte, Greensboro and Durham, psychiatric social workers must be secured for present needs before they accept further responsibility.

Further Clinical Needs

This means we have need for eight psychiatric social workers for out-patient work in addition to our plans for one at Butner. Space needs, psychiatric, and psychological supervision are other factors involved in the establishment of these clinics. This is in addition to raising and continuing local funds for these clinics and a basic relationship. Asheville, Charlotte, Greensboro, Durham, and Raleigh are interested and willing to cooperate when the personnel needs can be met.

We have worked out a cooperative arrangement with Graylyn Rehabilitation Center in Winston-Salem for treatment of alcoholics on an out-patient level. In their first six months of work, they recorded 84 patient visits, 34 new patients, 152 psychological tests, 234 hours of social work, 3 patients referred to Butner and 3 cases closed.

Alcohol's Relation To Alcoholism

While alcoholism is a serious and complicated illness, it has become so by neglect, inattention, and failure to recognize some underlying personality disorder. Alcohol alone does not bring about alcoholism. If it did, there would be far more than 950,000 chronic alcoholics or 4,000,000 excessive drinkers out of the 65 to 75 million users in our adult population.

Alcohol does aggravate the basic difficulty and create new problems of spiritual, economic, legal, physiological, sociological and psychological natures. Sometimes these complications are so complex and confusing that many sympathetic and interested persons waste

much time and energy emotionally attacking the symptoms and results instead of the causes of these problems.

This does not mean that the spiritual, social, physiological, economic or any other factors involved should be neglected. Indeed it is most important to the patient, the therapist, and the program that all resources be utilized and no facet be neglected.

Some Basic Aims

It is around this knowledge that we must aim our program of rehabilitation and prevention. I use the word prevention for that is the ultimate goal of any public health problem. And alcoholism is a public health problem and has been so recognized.

It is indeed important that the sufferer from alcoholism or any other acutely intoxicated person be provided some safety and protection until he becomes sober. There are other illnesses that may portray identical symptoms of inebriation and if not diagnosed and treated early may result in death. Acute intoxication may also aggravate some other condition in the patient bringing to a crisis this condition and resulting in death.

Urgent Hospital Needs

These deaths occur in homes and jails where medical examination is not present. The type of care and treatment required for these peopl can be had in any general hospital and by any medical practitioner regardless of his specialized training. Lives could be saved. Perhaps to drink again, it's true, but it is equally true he might live to receive further specialized treatment leading to health and rehabilitation.

SAFETY FOR THE SUFFERER

Great social and medical reforms do not blossom overnight and rarely, if ever, are they accomplished by those in positions of authority and responsibility except under pressure of new attitudes developed among the general population. An increased awareness by the masses must be activated until an aroused public demands of its physicians, administrators, and governing boards action to meet this old and growing need for hospitalization and medical care.

Success Through Free Facts

To be successful our program must remain free of entanglements with special interest groups or we will soon become known as a state-supported propaganda agency for some particular group. Here I use

the word propaganda in its narrowest sense. We must present the facts—all the facts—without bias or prejudice.

Before this can be done, vast amounts of literature on the subject material must be acquired, read, sifted, and classified. That which has a sound basis and is well founded upon careful and scientific investigation will be used. That which is based on assumption and emotion will be labeled and treated accordingly.

A NEW OUTLOOK THROUGH BUTNER

Name: ARP Treatment Center

Location: Old Camp Butner site

Space: Beds for 50 men patients

Cost: $72 for 28 days treatment

Requirements: Social history of each patient, giving family and educational—vocational background. In addition, the medical history of each patient, giving the necessary physical background and condition.

Treatment: Group discussions led by Medical Director, educational films, individual consultations with the doctor, vocational therapy class, recreation and rest, much good food and any prescribed medications.

Social History: To give the doctor a foundation for diagnosis and some guidance toward sobriety. The best compiler is the trained case worker.

Discharge: Patients are referred to the family doctor, mental hygiene clinic, and Alcoholics Anonymous. ARP follows progress of each patient.

TREATMENT IS VOLUNTARY, DESIRE IS COMPULSORY

Social Science Lends A Hand

The seriousness of alcoholism today is relatively greater than ever before. We must study it as patiently as we have studied the atom and the cancer. Our knowledge of this illness is so fragmentary and unintegrated that it demands such scientific study.

Through a contract with the Institute for Research in Social Science at the University of North Carolina, we are seeking scientific information on a number of aspects of our problem. A survey of practice of private physicians with regard to problem drinking in the state is now being compiled for general knowledge.

More fundamental inquiries of longer duration are underway on the relationships between problem drinking and such associated social problems as crime, delinquency, and industrial absenteeism.

Consideration is being given to exhaustive analysis of case record materials being collected through the Butner Treatment Center. Through this research at the University we are initiating what should become a continuing program of scientific research on the non-medical aspect of alcoholism.

HOW MANY BECOME PROBLEM DRINKERS?

Problem drinkers are those persons who drink to such an extent that they are exposed to the risk of becoming compulsive drinkers and developing the disorders of body and mind that sometimes accompany prolonged excessive drinking. Through their drinking they become problems to themselves and to others.

There are approximately 110,000,000 persons of drinking age—fifteen years and older—in the United States. Of these, 65,000,000 use alcoholic beverages.

Yale's most recent studies indicate that the number of serious problem drinkers is about 4,000,000, of whom 1,000,000 are excessive drinkers without addiction and 3,000,000 are compulsive drinkers in various stages of alcohol addiction. Of the compulsive drinkers, probably 1,000,000 have developed physical and mental complications. It is these who are commonly called chronic alcoholics.

Apparently 6 per cent of those who use alcoholic beverages become problem drinkers. This ratio is based on 1948 estimates of the number of excessive and compulsive drinkers and the size of the drinking population. It is not a true relationship, however, because of the number of years required to produce an alcoholic. A few alcohol addicts "get that way" within a short time—two or three years—after they begin to drink. But the great majority have a drinking history of at least ten years prior to the onset of addiction. In the decade before 1948 the number of drinkers in the United States increased nearly 40 per cent. A true index of the number of drinkers who become problem drinkers cannot be determined until the size of the drinking population—those who use alcoholic beverages—remains relatively constant for approximately ten years.

Problem drinking is much more prevalent among men than among women, the ratio being approximately 7 to 1. It has been asserted that inebriety among women is increasing at a faster rate than inebriety among men. Surveys show this not to be true. There has been an increase in the number of female alcoholics and inebriates because of the great rise in recent years in the number of people who use alcoholic beverages. But the ratio of male to female problem drinkers is higher today than it was in 1940 and considerably higher than in the preprohibition years.

Studies also reveal that problem drinking is more prevalent in large urban and industrial areas than in smaller cities, under 100,000 population, and rural communities. The rate of alcoholism in cities over 100,000 in population is more than twice the rate in rural areas.

It has also been observed that the rate of problem drinking within the drinking population is higher in states with a high proportion of dry sentiment than in states where the index of dry sentiment is low.

Alcohol and People, by Clifford Earle
Board of Christian Education
Presbyterian Church in the U.S.A.

NO ONE-MAN JOB

A VITAL MEMBER

Treating and arresting the illness of alcoholism is not a one-man or one-profession job. It takes the efforts of what ARP authorities like to call the rehabilitation team, a vital part of which is the county welfare worker who secures social histories of the individual patients.

In the words of S. K. Proctor, executive director of the Alcoholic Rehabilitation Program for the N. C. Hospitals Board of Control, "The heart of the treatment process might be called the social history. Social workers, especially those with the Welfare Department, are often familiar with the patient's environment. They're in a position to get information that would be difficult for a social worker in a central treatment institution to secure."

On The Scene Interviews

In Welfare language, these county workers are known as case workers, and their work is on the scene of environment. Such association allows first hand interviews of the patient and members of his family, or his employer and some friends. Vital details of the family and personal history begin to take shape with the domestic, economic, social, and occupational conditions of the environment. Cause, result, effect slowly unveil.

Dr. Lorant Forizs, medical director of the ARP treatment center at Butner, speaks enthusiastically about the value of the social histories compiled by professional welfare workers: "We attach the greatest value to these social histories on our patients, because they save time and help give us information the patient won't often admit. Those histories developed only by the patient and his family are usually very ineffective, and there have been some ineffective returns from non-professional compilers. But the social workers in the welfare group have done the most effective job so far."

Guides For Social Workers

Around 90% of the social histories compiled so far in the rehabilitation program have been done by the local Welfare workers. Containing a total picture on the patient, the informational outlines are issued by the Alcoholic Rehabilitation Program as guides for the social workers. The patient's total background is covered: early childhood, figures in early childhood, educational and occupational records, psycho-sexual development, court records, and medical history. Included are guides for any military background, personality and social adaptability, marital experiences, religion, habits with sedatives, and anti-social behaviors. Added to this are descriptions of the personality sober and intoxicated.

Rehabilitation Director Proctor emphasizes that this informational form is merely an outline. It is not a questionnaire to be filled out, checked off, sent in. At the foot of the eight-page guide are reminders of this fact: "It should be remembered that this outline of the patient's family history cannot possibly include all of the factors which might bring to light important and influencing background features. The above points have been listed as

a guide for the worker who must use judgment as to whether or not information obtained is relevant.

A Time-Saving Tool

The "excellent job" of the social workers often referred to by Proctor and Dr. Forizs is submitted to the center's physician-psychiatrist. In conjunction with psychological studies, this social history gives the doctor a biographical background, a time-saving tool, which sends him instantly into diagnosis and treatment of the patient. According to rehabilitation officials, the better informed the social worker becomes about alcoholism and its complications, the better able she is to develop an accurately detailed report of her observations. The keener her knowledge becomes of the sensitive and emotional traits of the alcoholic personality, the more valuable her report becomes to the doctors who treat that personality.

A few weeks ago the Alcoholic Rehabilitation Program issued eleven library-kits for use in the State Welfare office and among its ten field representatives over the state. Consisting of books, pamphlets, and memoirs, the informational kits provide the latest facts on alcohol and alcoholism to the various county welfare offices through the field workers.

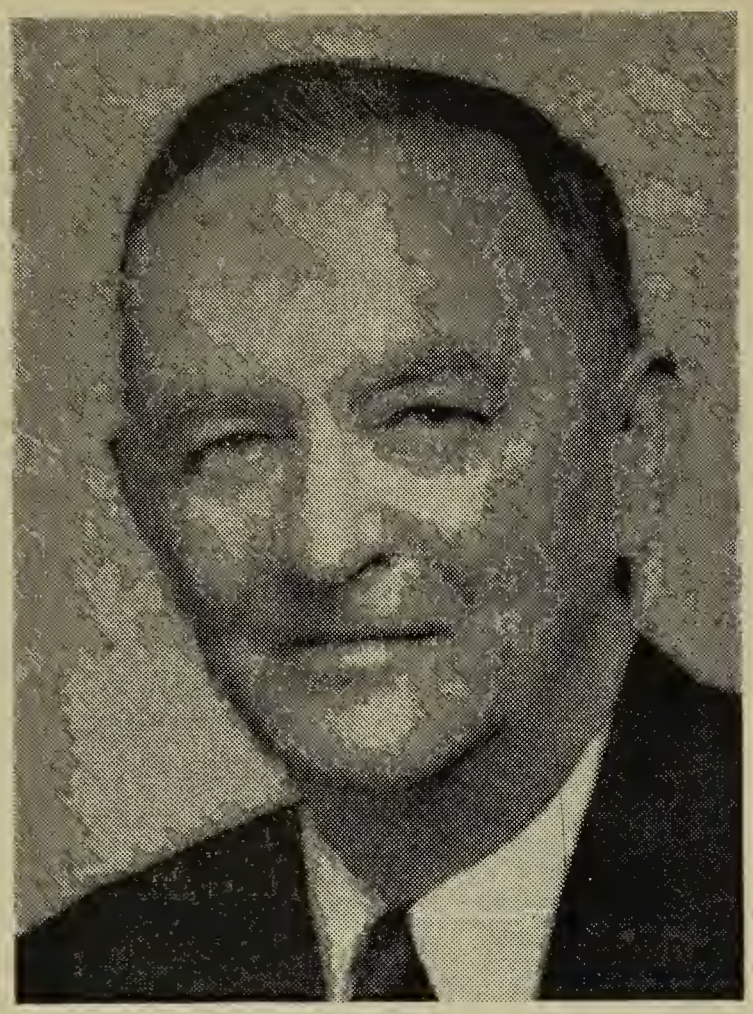
Not Numbers In A File

Director Proctor points out an effective similarity, "In our work with rehabilitation, we are concerned with the individual, like the Welfare Department. Our patients are not numbers in a file. They are individual persons with individual problems and individual solutions. We are concerned with the return of the patient to his community as a self-respected and community-respected citizen. When he becomes an asset to his community, a provider for his family and himself, the patient has paid his way."

A common error in many people's thinking is that social histories mean charity conditions. By no means are all alcoholics on the charity files of county welfare offices. The great majority of people ill from alcoholism are still able to carry on their lives, to provide for their families, sometimes on a shoestring, and always in spite of their illness.

Slow, Certain Realization

No one group is doing it or can do the job of rehabilitation alone. The problem is nearly as old as man and plant life and the natural phenomenon of fermentation. Slowly, certainly men have come to realize that it takes team work, that it takes the doctor-psychiatrist, the minister, the psychologist, the Alcoholic Anonymous, the socialogist, the social case worker. In one case, the doctor taps the root, in another case the minister, in another case the A.A. The problem is complex enough to require a team—a group that ARP officials like to call a rehabilitation team working to arrest the illness of alcoholism.



JOHN W. UMSTEAD, Representative from Orange County, was born and raised in Durham County, attended the public schools there and graduated from the University of North Carolina. Chapel Hill insurance executive, Umstead has always been a highly active civic, political leader.

Currently he is a Trustee of the UNC and member of its Executive Committee. He is a member of the Executive Committee of the N. C. Hospitals Board of Control, and recently served his sixth consecutive term in the House of Representatives. He is a Mason, an Elk, a Grange and Farm Bureau member, a Methodist and pioneer ARP supporter who worked for its creation.

THREE LAWMAKERS

"Whereas, the problem of alcoholism has been increasingly serious in its prevalence and in its unfortunate effects on persons so addicted, on their families and on the community; and

Whereas, treatment and care for alcoholic persons desirous of help in the early

FRANK M. KILPATRICK, Representative from Pitt County, was born and raised in Grifton in southern Pitt County. He attended school at Grifton, Johnson Bible College, Knoxville, Tenn., Lynchburg College, Lynchburg, Va., Southern Shorthand and Business College, Norfolk, Va.

Currently a realtor and farmer of Ayden, he is a member of the Rotary Club and the Pitt County Democratic Executive Committee. He has served three consecutive terms in the House. He is a deacon in the Ayden Christian Church and ardent co-author of the bill founding the Alcoholic Rehabilitation Program in North Carolina.

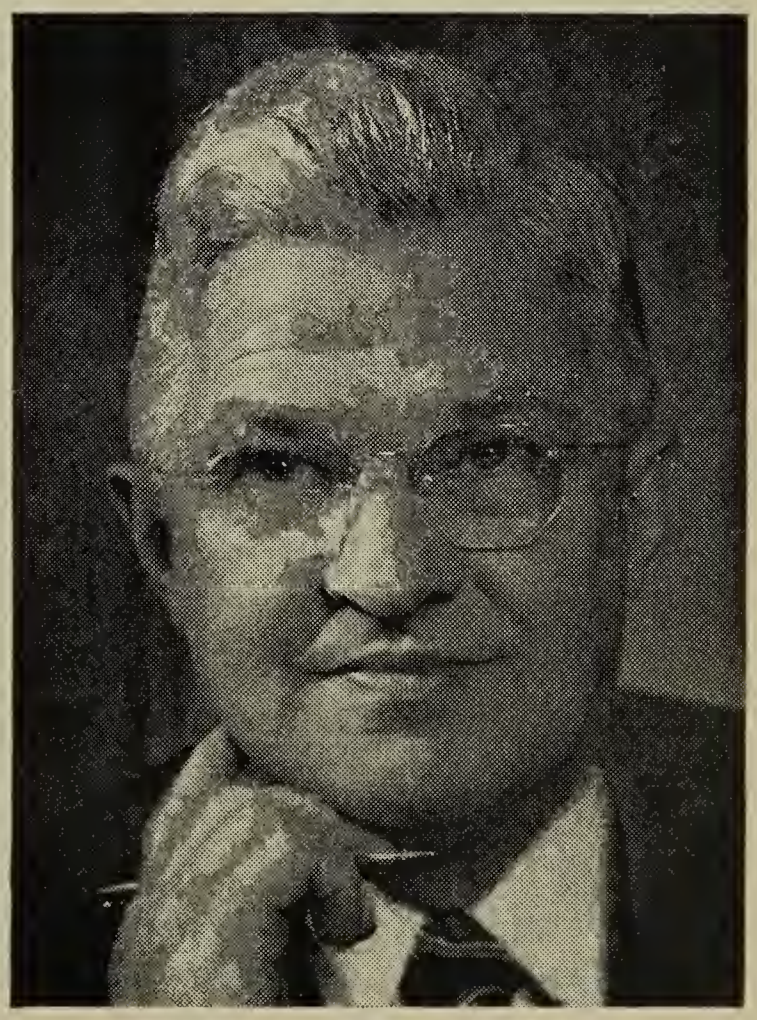
HERBERT CLIFTON BLUE, Representative from Moore County, was born in Hoke County when it was Cumberland County. He graduated from Vass-Lakeview High School and soon went into the newspaper field. Publisher of **The Sandhill Citizen** in Aberdeen, Blue is now a political and civic leader of Moore County.

He has served as president of both county and state-wide Young Democratic organizations, is a charter member of the Aberdeen Lions Club, an active Mason, Woodman of the World, and member of the Bethesda Presbyterian Church. Co-author of the ARP law, Rep. Blue is recognized through the Sandhills as one of the fathers of the ARP.

A CITIZEN, AND A LAW

stages, and in a setting conducive to retention of morale will bring the best results in improved health and avoidance of habituation:

Now, Therefore, The General Assembly of North Carolina do enact: An act to provide additional facilities in the care of persons addicted to the use of alcohol . . . and the authority to establish other mental health activities."



JOHN S. RUGGLES, prominent Sandhills businessman, was born and raised in Southern Pines. Graduating from the city schools, he later went into real estate business in the resort community. Later as an executive in the Farm Security Administration, he served as Regional Procurement Officer for 11 states with offices in Raleigh.

During the late war, he returned to Southern Pines to own and operate a large insurance business. Currently a member of the N. C. Hospitals Board of Control and Chairman of the Alcoholic Committee, he is an active Kiwanis and Chamber of Commerce leader. Among private citizens intensely interested in alcoholism, he is recognized as a leading, initial supporter of ARP.

A Physician
His Sister
& Alcoholics Anonymous

I am a specialist in internal medicine and diagnosis. Because I take care of more alcoholics than the average physician in my community, I am frequently asked the question, "How can you stand to mess with so many drunks?" My answer to that is, "I have a sister who is an alcoholic and who suffered for many years until she became a member of AA".

Unfortunately there are still too many doctors who do not fully understand AA. Even those who do understand the general principles of AA do not understand alcoholics in a majority of instances. I watched an alcoholic develop under my eyes, still I did not recognize the personality factors and the environment factors which were important in the development of this condition.

Years Of Agony

For several years little, if anything, was done for my sister's alcoholism. We sought the aid of a psychiatrist. As had been the experience of so many alcoholics, this was completely fruitless and expensive. As time passed, institutions began to be used. Finally in desperation the family, including myself, sought some knowledge of AA. To me it is extremely regrettable and even tragic that AA was not thought of first instead of last because with the calling on AA, began my education in alcoholism. Everything I now know about alcoholism has been taught me either directly or indirectly by alcoholics of the AA Groups.

Why are doctors generally so ignorant of the basic problems of alcoholism? In the first place, the teaching of alcoholism in the medical schools has been grossly inadequate. There are definite reasons for this, the major one being that alcoholism lends itself very poorly to didactic teaching.

In the second place, the care of alcoholics is extremely troublesome and in the past has been distressingly fruitless, both from the standpoint of the gratification of the patient's recovery and from the standpoint of remuneration to the doctor for his services.

Proud Of State ARP

Because the general public and leading medical schools are now learning more about alcoholism as an illness, future doctors will be better grounded. Citizens of North Carolina should feel proud that our State has begun a State Alcoholic Rehabilitation Program. This program, however, cannot succeed without cooperation on the part of the doctors.

Those of us who have seen alcoholic derelicts change into extremely useful, self-supporting, proud human beings under the influence of AA, have found sufficient gratification to keep our interest stimulated. Particularly is this true when one beholds with great pride his own sister's regaining the love of her children and the admiration of her friends through her own sobriety and through her work with the AA Group.

WHAT MAKES AN ALCOHOLIC?

A Plea To Physicians

I would like to issue a plea to every physician who reads this. Please do not turn down your alcoholic patient. Try to understand him and lead him into AA. If you salvage one out of ten, your efforts have not been in vain. Certainly we do not salvage one out of ten patients with cancer and yet no doctor turns them down.

What makes an alcoholic? Some of my friends in AA have told me that only an alcoholic can understand an alcoholic. I am not as yet an alcoholic, so perhaps I am presumptious in trying to describe an alcoholic's personality. The predisposition to alcoholism is a personality trait, perhaps with hereditary factors and certainly with factors which are influenced by his early development. Such things as infant and childhood rejection, frustration, jealousies, fears, etc., all go to mold basic insecurity.

This insecurity drives the person on to rather great attainments in one field or another. A high percentage of alcoholics are extremely intelligent and are quite successful for a time in whatever field of endeavor they have chosen. Eventually the stress and strain of responsibility is too great and "escape" is found in the bottle. From here on the alcoholic's thinking is tremendously distorted.

World's Greatest Rationalizers

The alcoholic is the greatest rationalizer in the world. Nothing is his fault; everything he has ever done is the fault of his wife or his mother or his father or somebody else. Frequently his ego is insatiable. Hence the long delay before he will admit that he is an alcoholic and that he needs help from outside. In his mind there are a maze of resentments, fears, and jealousies, but by rationalizing the blame on someone else the alcoholic absolves his own conscience and takes another drink. He is selfish. Nothing matters except himself.

What can the doctor do with an alcoholic? First of all, a doctor can be understanding, firm, and willing to help if offered the opportunity. He must not be solicitous; no one can help an alcoholic until he is ready to be helped. It is unfortunate that so many sink to tragic depths before they are ready to accept help. When the alcoholic is ready for help, he usually needs to be put in an environment where abstinence can be maintained. He is usually sick and mal-nourished, extremely tense and nervous. Consequently, hospitalization, confinement to a nursing home, or other institution is very frequently necessary.

No "Tapering Off"

There is no such thing as "tapering off". If an alcoholic will not quit drinking while the doctor is treating him, then he is not a medical problem; he is still a social problem. If he will quit drinking, and has already reached an advanced stage of alcoholic illness, he needs some type of emotional support with mild sedatives. This is a necessary but somewhat *dangerous* part of his treatment and the doctor should choose his sedative with great caution and discontinue its use as soon as possible.

As a general rule paraldehyde or chloral hydrate serve the purpose better

than do the barbiturates. During the initial phase of coming off a drunk, the alcoholic needs large amounts of fluids, frequently intravenously because he is unable to retain oral fluids. He needs large amounts of vitamins and he needs food as soon as he is able to eat.

Strength, Desire, AA

When he is completely sober and has regained a measure of his strength and if he indicates his desire for help, he should then be turned over to AA. This is as far as the doctor goes, but if he can accomplish this much, he can be just as proud of his efforts as if he had saved a life by dramatic surgery.

Saving an alcoholic is saving a life. It is more than saving a life. It is saving a family.

—Written by a North Carolina M.D.
From CHIPS, New Bern A.A. journal

Seven Methods Of Sharing An Educational Program

1—Through a bi-monthly magazine giving the scientific findings and personal views of state and national groups working toward the treatment and rehabilitation of the alcoholic, education and prevention of alcoholism among the general public.

2—Through feature stories on alcoholism and the rehabilitation program in state newspapers, professional-club journals, other periodicals.

3—Through a comprehensive brochure describing the N. C. Alcoholic Rehabilitation Program, its organization, aims, purposes, and services.

4—Through special lectures before civic clubs, P.T.A.'s, Health and Welfare organizations, educational groups, industrial groups, ministerial associations, and county medical societies.

5—Through radio scripts telling the nature of the illness, its far-reaching effects, psychological, sociological aspects, who can help and how.

6—Through symposiums, public forums conducted by reputable authorities on alcoholism for all citizens interested in specialized activities of different professions.

7—Through carefully prepared guides for health educators, professional case workers, public health nurses, ministers, personnel directors, public school teachers, and law enforcement officers.

Five Attitudes Toward An Ageless Problem

"No Room in the Ward"

BY SANTFORD MARTIN, JR.
ARP Educational Director

Among the thousands of hospital beds in North Carolina there are less than 150 beds specifically reserved for patients suffering from the illness of alcoholism, and only one of these is in a general hospital, a recent survey reveals.

There are five attitudes toward the hospitalization of persons suffering from alcoholism: the unconditional acceptance of problem drinkers, acceptance with certain reservations, admission for sobering and releasing only, admission for emergency or illness other than problem drinking, and no admission.

Eight institutions admit problem drinkers unconditonally, fifteen accept with reservation, 22 sober and release, sixteen admit only for emergency or other illness, and 54 do not accept alcoholic sufferers.

From A Scientific Survey

These figures come from a recent survey conducted for the Alcoholic Rehabilitation Program of the N. C. Hospitals Board of Control by Norbert Kelly, Research Fellow at the Institute for Research in Social Science at Chapel Hill.

The study is titled "A Survey of the Institutional Care Available for Problem Drinker Patients in North Carolina," and covers the answers of 123 institutions that responded from a directory of 169 organizations. Since eight were not open at the time of the survey, the formal study includes the facilities of 115 institutions.

In the group accepting alcoholic patients "with certain reservations" are the one general hospital bed and 147 mental and treatment center beds specifically reserved for the alcoholic. According to the study, only 23 institutions provide treatment for the long neglected addictive drinker.

The Need Of Protection, Treatment

S. K. Proctor, executive director of the Alcoholic Rehabilitation Program, declares, "The alcoholic sufferer or any other acutely intoxicated person should be provided some safety and protection until

he becomes sober. Deaths occur in homes and jails because medical treatment was not available to such people."

A major platform of the rehabilitation program is the ultimate establishment of small alcoholic facilities in various local hospitals through the cooperation of local medical groups, civic and welfare agencies, Alcoholics Anonymous, and others.

The 23 institutions providing "some kind of treatment" are classified in the following catagories: unconditional acceptance, six general and two mental hospitals; admittance with certain reservations, seven general hospitals, four mental institutions, and four treatment centers.

The Need for Versatile Treatment

Out of the eight unconditional hospitals none has a versatile treatment program for the individual needs of the individual patient. Antagonistic drugs and simple medication are the predominant treatment devices. Only one hospital utilizes psychotherapy, only one refers the patient to Alcoholics Anonymous.

Group therapy and psychodramatics are not used by any of the eight reporting. In one major instance, treatment consists only of withdrawing alcoholic beverages and serving as custodian for some 30 days.

On the other hand, the fifteen institutions accepting patients with reservations have "what is at once a broader and more individualized treatment program."

Nearly half the group uses individual psychotherapy, some employ group therapy and psychodrama, others use aversion and conditioned reflex, two apply spiritual remedy, and five refer patients to A.A. for follow up.

Though highly effective in the treatment of alcoholism, only two out-patient clinics and three social service departments are reported.

Figures Tell A Need

In the year Oct., 1949 through Sept., 1950 the combined group of 23 cared for some 1,672 alcoholic patients: the unconditional hospitals 518, those with reservations 1,154. The 16 institutions receiving alcoholics only for emergency or other illness admitted 123 sufferers, and the 21 sobering and releasing units accepted 181 patients.

This total means that 1,976 alcoholic sufferers out of over four million citizens received the benefit of some type of hospitalization during the year ending last Sept., 1950.

. . . OFFER "SOME KIND" OF TREATMENT

Concerning regional distribution of treatment facilities, the study reveals, "The most populous region, the Piedmont, has a population approximately five times that of the Mountain counties, though it has only twice as many facilities for problem drinkers." This amounts to 13 institutions for 36 counties totaling some 1,968,523 people.

Unbalanced Distribution

Though second in population and three times over the Mountain area, the Upper Coastal Plain has only half as many institutions as the Mountain counties for serving alcoholic patients. This means the Upper Coastal Plain has three institutions serving 24 counties totaling 1,189,748 people, and the Mountain area has six institutions serving 17 counties totaling some 396,748 people.

A Revealing Summary

The survey concludes, "In like vein, the Tidewater, with 100,000 more people than the Mountain region, has only one-sixth as many institutions." Literally, only one institution serves the 23 counties of the Tidewater totaling 496,711 people.

In summary, there are only 23 institutions willing to offer "some kind of treatment" for alcoholism to a state of 100 counties and 4,051,730 citizens, and only 13 of these are general hospitals.

General hospitals tend not to reveal their acceptance of problem drinker patients in their daily census lists. In fact, the average patient load reported by the six unconditional general hospitals totals one, though they treated some 103 alcoholics in the surveyed year.

Once Again—The Stigma

Once again natural concern for community opinion guides the policy of well-meaning institutions anxious to remain clear of the prevalent but unfair stigmas associated with the complex illness of alcoholism.

This condition is not the fault of the medical profession or hospital administrators. It is caused by public opinion, even more public prejudice. Too often community leaders raise an eyebrow instead of a helping hand toward such vital public problems.

The state ARP office believes all hospitals should accept alcoholics openly, and should insist that such addictive drinkers be listed on the census as patients suffering from alcoholism.

The age of whispered shame, once attached to tuberculosis, cancer, and leprosy, must now be lifted from the primary illness of alcoholism.

Helping Patient Feel Accepted Is Major Work Of The Therapist

The overwhelming majority of professional therapists agree that psychotherapy plays a part in every successful outcome of the treatment of alcoholism. Whether it is the only measure or is used in conjunction with some pharmacological or physical treatment, psychotherapy is believed to be indispensable.

Healing Through Psychological Approach

Psychotherapy—healing through a psychological approach, as the term implies—comprises a vast number of different ideas and can take on many forms and aspects. Perhaps no two psychotherapists have exactly the same concept of the term. Each psychotherapeutic process is conditioned by the personality and the beliefs of the therapist, by the personality and the type of disturbance of the patient, and also by the interplay between the two personalities as well as the circumstances under which treatment is given. One aspect of psychotherapy, as described by psychiatrists specifically in connection with the successful treatment of alcoholic patients, is here presented.

According to C. L. Brown (Topeka, Kans.) the essential feature of psychotherapy is the establishment of a certain relationship between the patient and the therapist. This new relationship, generally called "transference," is achieved by any of a variety of techniques by which the patient is brought to realize that he is "accepted."

The Need For Acceptance

The alcoholic especially needs to be accepted because he has been well-nigh universally rejected. He is generally viewed, at best, as a rather enigmatic fellow, who for some reason seems to take a strange satisfaction in behaving in unacceptable ways, and who is unable to exert his will power. He aggravates matters by seeming to manufacture situations in which he will be rejected and frustrated. He thus needs acceptance above all else; upon this need and its fulfillment rests the subsequent progress in the therapeutic process.

The patient must be made to feel—it is not a question of intellectual persuasion—that he is truly and sincerely accepted by the therapist.

Once he reaches this feeling, old patterns of behavior, which were operative because of that need, no longer have to persist. He can begin to cooperate with the therapist and he will gradually be able to gain insight into his problems along with relief of the symptoms.

Approach To "Chronic Complainer"

The technique used by the therapist to convey to the patient the fact that he is accepted is illustrated by Brown with the case of a patient treated at a veterans hospital.

The patient was a 36-year-old man, of a highly irascible disposition, who complained often and at length of such symptoms as headache, backache and insomnia. He claimed that he drank to alleviate these symptoms. In the hospital he complained at every opportunity and was sullen and sarcastic. A thorough investigation did not reveal any organic basis for the physical symptoms.

During his third interview with the therapist, the patient showed his defiance by saying, "I guess you think I'm just a chronic complainer." The therapist replied that while there were no organic bases for the complaints, the symptoms in question were quite real and could easily be due to emotional disturbances. He then explained the mechanism by which such symptoms may come about and offered his help in investigating their exact cause.

A Smile, Then Transformation

At this point and within a few minutes the patient underwent a transformation. He smiled, appeared a little uncertain at first, and then began to speak of his early childhood frustrations. From then on he improved rapidly. His physical symptoms disappeared within 2 weeks and he became cooperative with the therapist and on the

Inventory's Link With International Findings

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Through this service INVENTORY brings to its readers the latest facts on alcohol and alcoholism compiled by International authorities in the various fields related to alcohol problems.

ward. Later interviews were occupied with the working out of his problems. The patient was soon able to get a job; he had kept out of mischief and abstained for the 9 months from his discharge to the time of the report.

Brown believes that the change in behavior took place because of an emotional experience which occurred at the third interview. By his original provocative behavior the patient was inviting retaliation, which would confirm his feeling of rejection. When the therapist did not retaliate but instead showed that he accepted the patient with his problems, the patient was dumbfounded. At that moment he felt truly accepted for the first time.

Akin To A Conversion

Brown suggests that such an experience is akin to a conversion, and compares his observations to those reported by H. M. Tiebout. The experience is not necessarily as clear-cut or sudden in all patients as in the illustrative case, but it is essential for the successful outcome of treatment.

Tiebout (Greenwich, Conn.) has discussed the conversion experience which many patients treated for alcoholism undergo. He defines conversion as a psychological event in which there is a major shift from a negative, hostile attitude to an affirmative, cooperative one. Tiebout believes that the key to an understanding of that experience may be found in the act of surrender by the patient which sets in motion the mechanism of conversion.

In Response To Events

The act of surrender is not a conscious one and cannot be willed by the patient. It occurs in response to events which force the patient at last to realize that he is unable to go on without help. Hitting an emotional "bottom" is apparently needed in order to provoke this realization. Psychotherapy begins, however, before the patient has reached this stage. The early object of psychotherapy is to help the patient reach it, and the exact technique must be fitted to the individual patient and circumstances.

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Getting The Alcoholic To Cooperate

In his informative family guide on alcoholism, Ernest A. Shepherd, Director Division on Alcoholism for the New Hampshire State Department of Health, gives five suggestions for getting an alcoholic to cooperate.

Seeking outside help is the alcoholic's only hope, and the following steps are the New Hampshire director's recommendations to the family:

First you must consider frankly what the condition is with which you are dealing. If the danger signs and the behavior which goes with them have appeared, the condition is not one which will change quickly even though the signs may disappear for long periods of time. You are dealing with a sick person and unless this is understood there will be little chance of having an alcoholic seek help.

Secondly, make it easy for the person to admit he needs help. It is quite natural, when you see someone you like or love destroying himself with alcohol, to beg him to stop, to appeal to his "better nature" and if that doesn't work, to threaten. But these just don't work. By and large, at this point, the friends and family of an alcoholic are so close to him and so mixed up with his problems and mistakes that neither they nor he can give help or take help from each other. There is very little they can do to secure the alcoholic's cooperation. *Most of the time it is someone from outside the family circle or social group who will be able to do the most good in helping the alcoholic admit his problem.* It may be a family doctor, or a social worker, or it may be a member of Alcoholics Anonymous. These people are not close to the person and he feels free to talk about himself in a way he never could with his friends and family.

It is a frequent experience that a person seeks help because he has read a newspaper story, magazine article, or a book which has explained to him his condition. Such an article or book allows him to see his own situation without criticism or threats.

These are all indirect ways which will help make it easy for the alcoholic to admit he needs help.

The third suggestion is similar: avoid nagging. The alcoholic already knows he has caused trouble, has a dozen excuses for his behavior, doesn't really know why he has done as he has, and is just as miserable as the rest of his family, but lecturing and "pep talks" only strengthen his suspicion that you either don't understand him or don't like him. But this doesn't mean you endlessly tolerate unpleasant or perhaps dangerous conditions. There may come a time when you must look after your own interests.

The fourth suggestion is *firmly, kindly, frankly* to discuss his drinking, making clear what you wish he would do and telling him why. Then—have patience.

When you have done this, the fifth suggestion is to not over-protect the person from the natural consequences of his drinking. It is not good for the alcoholic nor is it good for the family to be always on call as a rescue squad when the person gets into trouble. Sooner or later the patient must be left alone to confront and be confronted by the circumstances he brings about. It is generally no help to him or anybody to protect him from the effects of his drinking ways.

There may come a time when a member of the family feels he or she cannot stand any longer the drinking of the other partner. If that time comes, then be sure to face what a break may mean; consider it in every way, and then see if help is available for each part of the broken family.

In working to get the cooperation of an alcoholic, it must always be remembered that there is no substitute for the person's intention to recover. This cannot be forced on any person. An alcoholic, like any person, must decide for himself what he wishes to do about and for himself. Such a choice can only be made by a person in his own thinking and feeling.

Treatment Of Delirium Tremens Improves With Time, Experience

Delirium tremens is the classical disease affecting the nervous system in chronic alcoholism. In the past the severe symptoms lasted over many days, often a week or more, and the rate of death sometimes was reported as high as 75 per cent.

The treatment of delirium tremens has varied with time, according to the prevailing theory of its cause. The belief that the condition was precipitated by the withdrawal of alcohol resulted in medication with whisky or brandy. A modernized form of this practice, introduced in France by L. Bruel and R. Lecoq, includes the administration of alcohol intravenously.

Theories And Causes

The belief that delirium tremens was due to impairment of liver functions led to treatment with decholine. The frequent finding of "wet brain" after death from delirium tremens gave rise to the suspicion that the condition was due to cerebral edema, and hence to treatment by drainage of cerebro-spinal fluid.The list of drugs which have been used in the treatment of delirium tremens includes strychnine, rossium and amphetamine.

In the United States in the past 10 years the treatment of delirium tremens has been dominated by the administration of sugar, insulin and vitamins, chiefly of the B complex. This parallels the development of the concept of disturbed metabolism as the outstanding factor in delirium tremens. The majority of therapists withdraw alcohol at once.

J. Thimann and P. Peltason (Boston) administer glucose in 50 per cent solution by vein; 15 or 20 units of insulin, 100 mg. of thiamin chloride and 100 mg. of nicotinic acid are given by intramuscular injection at the same time.

Nursing Care Emphasized

J. A. Wallace (Memphis, Tenn.) administers digitalis routinely. Alcohol is withdrawn abruptly, and paraldehyde is used for sedation. Glucose, insulin and thiamin Chloride are administered by intravenous injection, and fluids are forced. Special attention is paid to nursing care.

ADEQUATE NURSING CARE

R. V. Seliger (Baltimore) describes a treatment for ambulant patients with uncomplicated delirium tremens: After a brief physical and neurological examination in the doctor's office, the patient is given 1 or 2 grains of phenobarbital, 3 grains of sodium dilantin and an intravenous injection of between 1,000 and 2,000 cc. of 10-per cent dextrose in normal saline. In the course of the injection between 330 and 660 mg. of thiamin chloride and 25 units of insulin are introduced.

Candy, Sugared Orange Juice Given

Additional doses of phenobarbital and dilantin may be given if needed and a second intravenous injection may be administered several hours after the first. Alcoholic beverages are not given, but candy and sugared orange juice are offered. Seliger states that this treatment will clear up uncomplicated cases of delirium tremens, in patients under 55 years of age, in about 10 hours. In some cases a third injection of dextrose, thiamin and insulin is recommended for the next day and the sedatives may be continued for several days.

J. J. Smith (New York) has recently treated patients in delirium tremens with adrenal cortex extract (ACE) and adreno-corticotropic hormone (ACTH). In this condition ACTH proved more efficacious than ACE and the improvement with the former was striking. Six patients received ACTH by intramuscular injections in doses of 25 mg. every 6 hours around the clock.

PLUS MODERN TECHNIQUES

No Sedatives Given

They had no other supportive medication, nor were any sedatives given. Improvement began to be noticeable between 3 and 10 hours after initiation of the treatment. Complete absence of all clinical signs of the disorder was noted between 18 and 24 hours after administration of ACTH was begun.

Thus the application of modern techniques of intensive treatment, including adequate nursing care, has practically abolished the incidence of fatal outcomes in delirium tremens and markedly reduced the severity and duration of the symptoms.

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TO THOSE WHO KNOW, WHO CAN UNDERSTAND—

This initial issue of INVENTORY is dedicated to the staff and patients of Butner Alcoholic Treatment Center. Scores of men have been treated at the ARP Treatment Center since September 1, 1950, and scores of successes have been registered.

For all of these sick but brave men this educational journal is created in the hope it will throw needed light on a vital health problem too long unsolved by provincial stigmas. It is created to show that their new look upon society depends greatly upon society's new look upon them.

Also to all North Carolina men and women anywhere, everywhere who know the tortures of alcoholic addiction, this journal is dedicated in the hope it might encourage in them a desire for treatment and help. To those who have found themselves, our strongest wish is for continued success.

To the doctor, the minister, Alcoholics Anonymous, the case worker, the teacher, the law officer, the Salvation Army, and the general public, INVENTORY dedicates the latest facts on alcohol and alcoholism as compiled by our own North Carolina program and the official clearing house for all developments in alcohol problems, Yale University.

Too Long Neglected

Thousands of North Carolinians have shown an interest in alcoholism as a social problem, but relatively few have accepted it as an illness and the alcoholic as a sick person.

To believe addictive drinking is an illness is to take the first step toward understanding a problem as old as the Commonwealth.

What does sickness imply? Does it suggest treatment and possible recovery? Does it suggest a needful person worthy of help, an individual not fully to blame? Does it suggest the extended hand of modern medicine, health education, and enlightened people?

The whole history of alcoholism is filled with the efforts of well-meaning zealots who were able to raise a respectable eyebrow as long as they could keep "Uncle Snort" upstairs in his room "where he belongs".

Too long have the Uncle Snorts been sick, forgotten, neglected not only by their families and friends but also by physicians and hospitals. Too long have they been confused, misunderstood by religious crusaders. The blame isn't easily placed. The fault is with the public, with all of us.

The failure has been one of inertia, of convenient blinders to what exists rather than what seems to exist. We have failed to realize that people don't drink to excess habitually because they want to. We find it hard to separate personality sickness from moral decay, or inner need from traditional "weakness".

According to Lawrence Kolb, former Assistant Surgeon General of the U. S. Public Health Service, "Many of these people could be saved, if in the early stage of their chronic alcoholism, they were handled like sick people instead of being treated like criminals or left to shift for themselves."

The conception of alcoholism as "a disease" is not new. For 150 years the idea has appeared and disappeared in scientific literature, never reaching the heart interest of the general public where most progress is reared.

In the early days of the Republic, Benjamin Rush, eminent physician of the Revolution, called excessive indulgence an "odious disease." His was the first American medical work on the effects of alcohol. But such men were always in the minority. Until recently the idea has been only a vision of medical pioneers with limited audiences.

It has always been easier to turn the problem over to emotion than to attack it through intellectual research. It has always been "courageous" to shout "poison, poison" while running frantically away from the "bum".

Until the general public recognizes alcoholism as an illness and the alcoholic as a sick person, we can safely presume the "bum" will continue to feel like "a bum", act like one, and suffer like one.

Until we exchange the inevitable jail for the hospital ward, we can hardly expect the problem drinker to care, to want, or to try. Desire to quit must exist, and perpetual public scorn never built such desire.

When the alcoholic "bum" and our "Uncle Snorts" become accepted patients, a major North Carolina health problem will be on its rightful way toward the laboratory, the hospital, and the medical profession.

Santford Martin, Jr., Editor

INVENTORY

If we are to understand the illness of alcoholism, we must take an inventory of what we know and don't know about beverage alcohol and human personality.

If we are to solve the problems of alcohol, we must identify ourselves with the illness of alcoholism. Major and *curable* maladies of today were considered incurable for years, until society chose to tackle them rather than avoid them.

Such identification takes teamwork. It takes the hospital and its physician, the church and its minister, Alcoholics Anonymous and its experience, the family and its newspaper, the public school and its teacher, the radio and its public forums, the health, welfare departments and their trained case workers.

APPLICATION FOR SECOND-CLASS
ENTRY PENDING AT POST OFFICE,
RALEIGH, N. C.

INVENTORY

NORTH CAROLINA

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

Published By THE N. C. ALCOHOLIC REHABILITATION PROGRAM

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S. K. PROCTOR.....*Executive Director, ARP*

SANTFORD MARTIN, JR.....*Editor - Educational Director*

APPLICATION FOR SECOND-CLASS ENTRY PENDING AT POST OFFICE, RALEIGH, N. C.

BUTNER—AN ATMOSPHERE

Recently a North Carolina minister wrote a Butner Alcoholic Rehabilitation Center patient in whom he was personally interested. This pastor revealed an insight into the Butner treatment and into the misconceptions of many citizens unfamiliar with the ARP work at Butner.

In referring to these misconceptions, the preacher wrote the patient: "I am counting on you to be a great help to others when you get home. So many people have no conception of what the treatment is, and all they can picture is that it is a place of confinement where the patient is forcibly kept away from alcohol and then hope that the habit is broken when he is discharged."

These remarks were presented to INVENTORY by the patient in the hope "this journal might clear up any mistaken ideas about the Center." The ARC at Butner is, of course, a State treatment center for alcoholism. Much more than custodial care, however, is offered the patients. It is a new venture in its approach to this insidious illness.

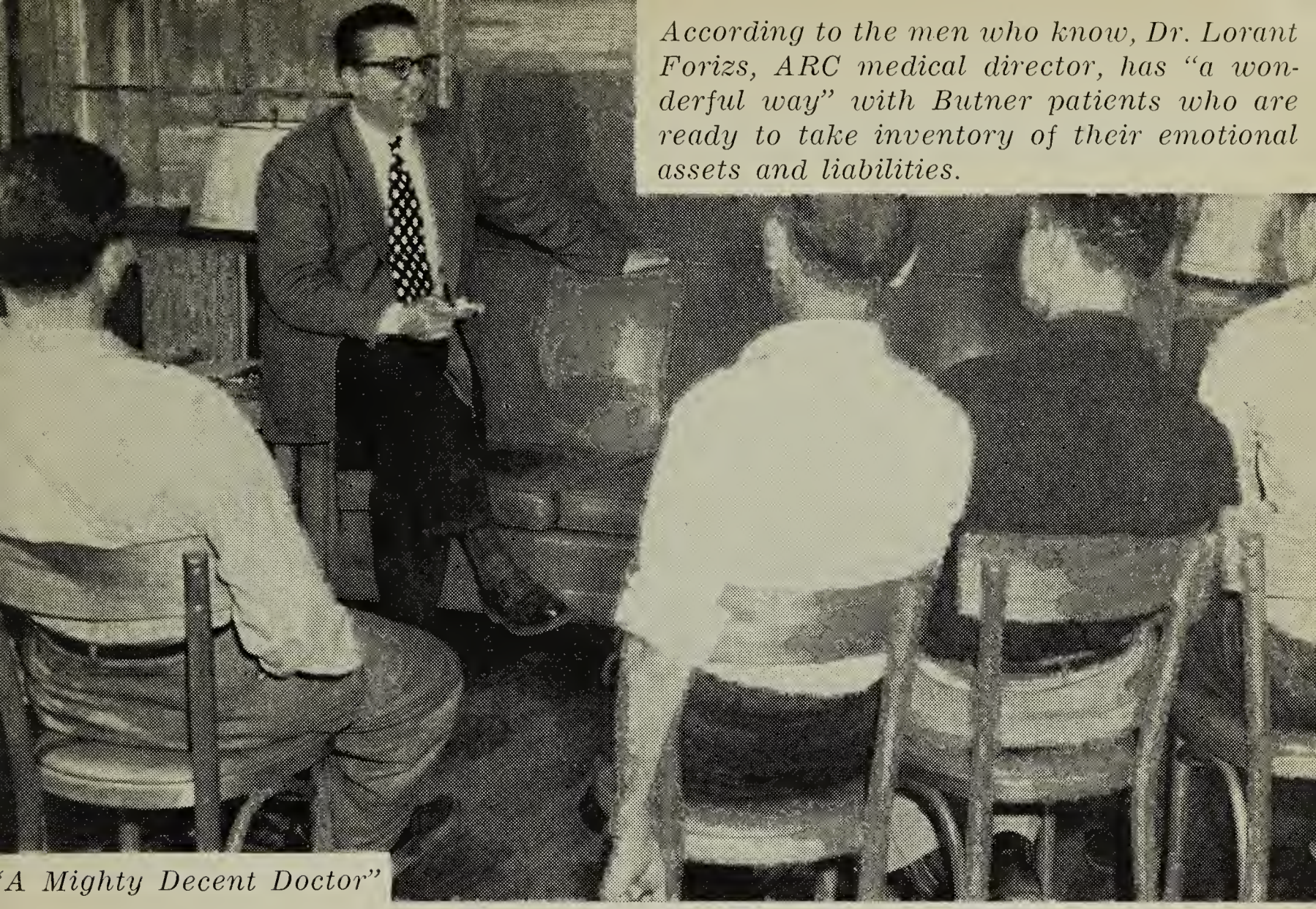
To a great extent, the Alcoholic Rehabilitation Center at Butner is an atmosphere. There is, of course, expert system in the treatment: planned diets, necessary medicines, stimulating group discussions, films on personality development, private consultations, recreational facilities, occupational therapy sessions, and time for meditation.

There is expert system, but there is more. There is an atmosphere which accounts for Butner's popularity among many sufferers of alcoholism in North Carolina. Perhaps a current patient's response can explain the atmosphere.

In Joe's eyes there was a story untold, a drama of fear and resentment. He wanted to tell someone he was feeling different, hopeful down inside, but he was hesitant. His hesitancy was born of fear, his fear of resentment, his resentment of the past.

His past had been a bitter dark age of commitments and confinements, of lock and key and dingy cells musty with criminal insanity and typhoid shots. It had been 30 to 60 days of just waiting to go home, to become bitterly conscious of Main Street stares and barber shop whispers.

It had been the quick beer, the anxious glance down cafe counters to see if any of the home folks recognized him and knew this was the beginning of another hopeless binge for Joe.



According to the men who know, Dr. Lorant Forizs, ARC medical director, has "a wonderful way" with Butner patients who are ready to take inventory of their emotional assets and liabilities.

"A Mighty Decent Doctor"

Joe's past was an age of loneliness in which the town constable, "the courthouse solicitor", the "recorder judge", and "the family" couldn't seem to tell him why he did what he did but could always tell him where to go for doing it. Where he had gone, what he had received, why he had returned so often was a vicious, mysterious cycle to Joe.

For the first time in that vicious cycle, Joe had come to Butner. After only three weeks, there was hope, a hesitant but budding faith in his eye. Joe wanted to talk but was cautious with his words. He said directly and between the lines, all at the same time:

"Butner's different. Butner's like daylight after an awful foggy night. No bars on the windows, no guards, no cells, no stinking cold food. Butner greets you like a man, shakes your hand, shows you to your room and a restful lounge and decent rules, and a mighty decent doctor.

"Butner gives you confidence, a place where men like me can get our bearings, no fence around the lawn, that means so much to a man sick from drink. Mainly, it has separated sick problem drinkers from the mentally insane."

A major part of this "atmosphere" touching many Butner patients is the Center's personable medical director, Dr. Lorant Forizs, the amiable attendants, E. C. Keith, L. M. Holland, J. W. Miller, and E. L. Hoyle, and the sympathetic dining room hostess, Mrs. Marcus Wall.

Though Joe came to Butner voluntarily, he left much of his confidence behind. "State institution—state hospital—voluntary?" A catch somewhere. Soon he found the catch—when a man can no longer obey the rules of conduct and follow the voluntary treatment, he is free to leave.

To Joe of the midnight cells and the Main Street stares, Butner's ARC is a new atmosphere in which scorn, ridicule, hatred are forgotten, where everyone understands "the other fellow's" desire to be well again, and self-righteous condescension is unknown. THE EDITOR

Newbill The Newcomer

By JOHN MENDENHALL
Psychologist
Butner Alcoholic
Rehabilitation Center

"Slow down to twenty miles an hour, dear. Didn't you see the sign back there? We don't want to have an accident?" The old lady's voice rasped like a buzz saw in my ear. I glanced over at my wife, Betty.

"Yes, Mother." Betty applied the brakes and slowed the car to a crawl.

Go stick your head in a pointed bucket, I thought to myself. This isn't your car. Old Stone Face had to run everything around her. I looked out the car window to take my mind off the shaking feeling I had had for days since coming off the last bender.

A large white building set back from a green lawn slid by on the right.

"Get a load of that, Betty. That must be where the big shots come to spend their week-ends in style. Shall I tell them to reserve it for my twenty-eight days?"

A dead silence hung in the air and gathered dust for a minute. Then old battleax boomed out.

"You better keep your cheap comments to yourself, Newbill. These people are doing you a favor by letting you come here. Why they try to do anything for a bum like you is more than I can see. If I had my way, you'd be in jail!"

The Devil! I spoke to myself, but I didn't say anything to her.

"Now, Mother, leave Newbill alone. He's trying to do what's right." Betty's tones were warm.

In the little pause that developed I could see Betty's face working. It was a cinch that she was thinking of the old days when her mother and I used to get along pretty well. She may have been thinking of my twelve convictions for public drunkenness; and the way I hadn't supported my family during the past five years.

It was a long time since her Mother and I had got along. Why did she have to tell me about all that she had done for me? That always scalded me. Then I couldn't say a decent word to her. I guess I had my part in the game, too, but I wasn't going to admit it to anyone else.

The car drew up in front of a red brick building with a sign "State

Hospital at Butner" over the entrance. We went in to a desk near the door where the old girl took over as usual.

"This is the patient for the Alcoholic Center we called you about. I am Mrs. Ronald Weathersnake." This as though she expected a throne to be brought immediately.

"What is the patient's name?" the red-head at the desk came back in a business-like tone.

"Him? Oh . . . Mr. Newbill Doakes." The old lady came out with it as if she were discussing the bubonic plague.

"Just have a seat in the waiting room, and I'll call the doctor."

A couple of minutes later this character comes in. He's short and stocky with horn-rim glasses.

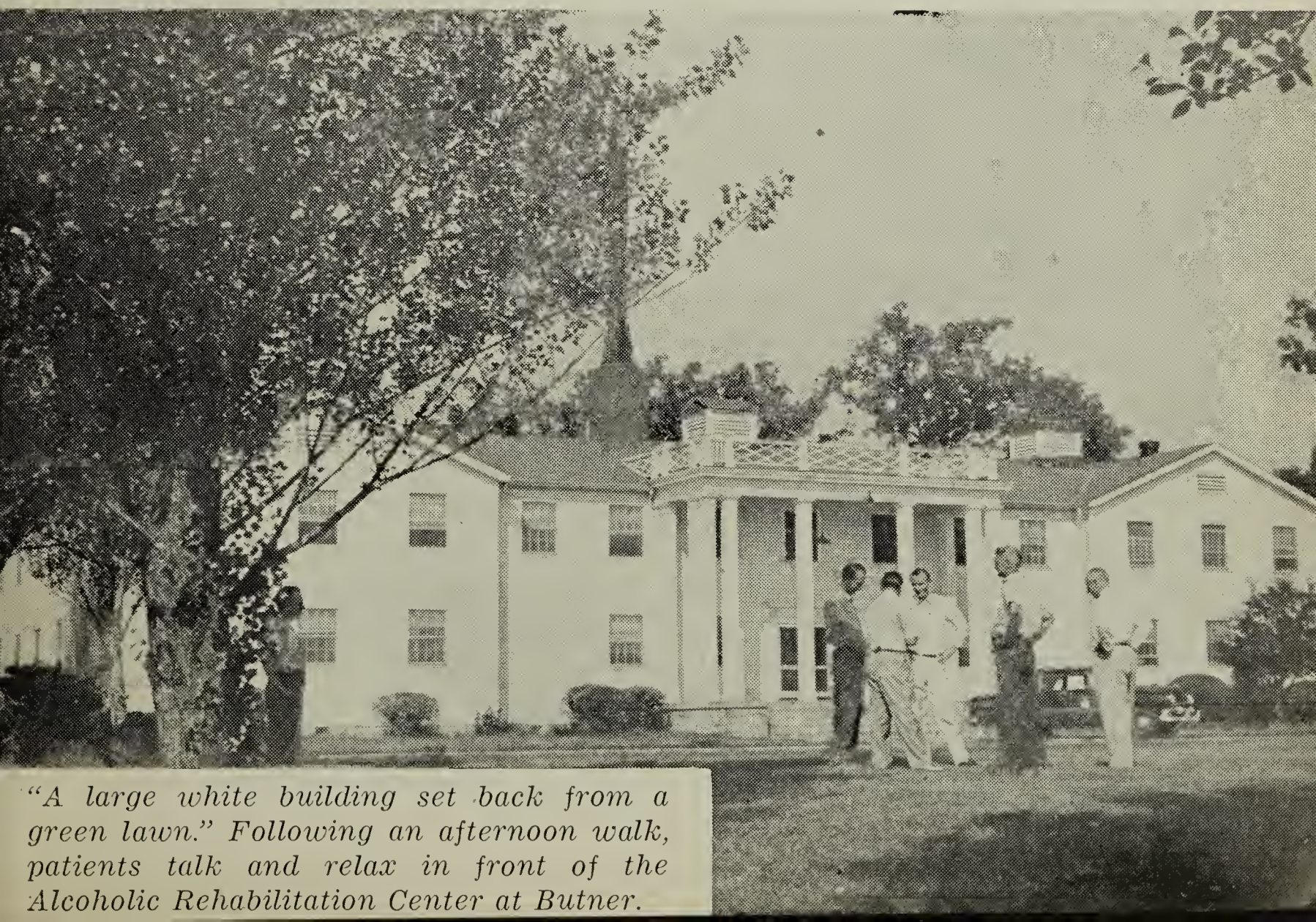
"I'm the doctor on call. You have a patient for the Alcoholic Center?" His voice had a slightly foreign accent.

"Yes, doctor."

"Do you have a social history, and, of course, the seventy-two dollars?"

"Yes, doctor."

"May I have them, please? If you will wait outside, I will examine the patient."



"A large white building set back from a green lawn." Following an afternoon walk, patients talk and relax in front of the Alcoholic Rehabilitation Center at Butner.

AGREES TO COOPERATE

"But doctor, can't we stay?" The old buzz saw sounded a little disappointed.

"I'm sorry, but since I must make a physical examination . . ."

"Oh! . . ." After the dust settled, I wondered what came next.

The doc came over and asked a few questions. He gave me a short physical and said that I was all right. He didn't seem to notice the way my hands were shaking. Then he brought out some papers for me to sign which said that I volunteered to come here and that I wouldn't get any money back if I left before the twenty-eight days were up and that I agreed to cooperate and abide by the rules and regulations of the joint. I wondered for a minute what I was getting myself into; then I signed them.

Five minutes later after getting directions to the place, my wife and my keeper, spelled m-o-t-h-e-r-i-n l-a-w, drove to the Rehabilitation Center. As we drove into the front, I looked at my home for the next month.

"Hey, you've made a mistake! This is that classy joint that we saw from the road."

"And this is the place where you're going to live. Looks like they are going to pamper you!" You know who had started letting out her hot air again.

A big, but happy-looking guy came out to take my bag in hand. "Good afternoon. I'm one of the attendants here."

I sized him up. He didn't look like a strong-arm guy, but it was hard to tell sometimes. Besides, he no doubt had plenty of buddies.

"Well, Betty, I'll see you. Take care of the kids." I kissed her.

"She always has without any help from you." "Mother" couldn't resist a final dig. I didn't even look back at her.

The inside looked as nice as the out. It was paneled and looked as clean as a pin. It must take a lot of work to keep this place up, I thought. Yeah, and you know who will be standing over me to see that I do it, too, I said to myself, looking at the guy carrying my bag up the stairs.

He led me into a small empty room. He helped me to unpack and put my things away. All this time I was thinking about a drink, but I didn't get one. He said, "Come on down and meet the other guys."

There were a bunch of guys sitting around a big room with some tables and a radio that was blaring out something about a guy who wanted to know if some babe had the money 'cause he had the time.' Over in one corner was a billiard table with a couple of men shooting

eight-ball; in another corner someone else was reading a Bible. The big guy in white said to everybody in general and nobody in particular, "This here is Mr. Doakes. He's a new patient. He's to be with us awhile."

A couple of characters said "Hi" or something like that and kept on reading. A couple others looked mildly interested. One came over.

"This is the president," the attendant introduced us.

"You mean you guys have your own officers like in a club?"

"That's right, Mr. Doakes. But we do a lot of the work around here and will expect you to do your part." This president had a voice like a bass drum.

"All right, you guys, let's get some chow." The guy in white didn't have to mention it twice. Everybody started moving toward the hallway.

The food was served cafeteria style.. There were a lot of small tables set around the dining room. I sat down at one of them with a couple of young-looking guys who turned out to be a salesman and a farmer, both from the southern part of the state. The food wasn't bad. It was a whole lot better than I had eaten many times at more expensive joints than this. I didn't talk much since there wasn't a whole lot to say. I was here to get cured. From now on it was up to the doc. I had done my part. They could do theirs, or so I thought.

I found out soon enough that no one was going to force me to do

A NEW OUTLOOK THROUGH BUTNER

Name: Alcoholic Rehabilitation Center

Location: Butner, N. C., 30 miles northwest of Raleigh.

Space: Beds for 50 men patients.

Cost: $72 for 28 days treatment.

Requirements: Social history of each patient, giving family and educational—vocational background. In addition, the medical history of each patient, giving the necessary physical background and condition.

Treatment: Group discussions led by Medical Director, educational films, individual consultations with the doctor, vocational therapy class, recreation and rest, much good food and any prescribed medications.

Social History: To give the doctor a foundation for diagnosis and some guidance toward sobriety. The best compiler is the trained case worker.

Discharge: Patients are referred to the family doctor, mental hygiene clinic, and Alcoholics Anonymous. ARP follows progress of each patient.

TREATMENT IS VOLUNTARY, DESIRE IS COMPULSORY

anything, but if I wanted to stay here, I was going to have to do a little work myself. The first thing was when the president assigned me a daily sweepdown task. If I didn't like it, the door was wide open.

The next morning I swept down and read a magazine. About 10:30 another one of those guys in white called us over to a long low building with chairs where he said we were going to see a movie. That movie seemed kind of pointless at first to me. It was all about some guy who had been raised all wrong. There wasn't anything in this picture for me. Then some of it hit me. I had done exactly that same thing to my little girl, Jane. I knew it was wrong at the time. Well, maybe some of these other men would want to learn how to be good parents, but I didn't come here for that.

After the show we went back to the big room. We sat around and talked for a while and then the doc arrived. He took a chair in the center at the end of the room, and we all gathered around him.

"Well, what did you get out of the picture?" He looked around. Nobody said anything for a minute.

Then up piped one of the guys nearest the doc. "I think that it was all true, doc."

"In what way?"

"Well, I don't know. I've done that same thing to my kids, sometimes."

Another man, a big guy with a crooked-look piped up, "It was all too easy. Reminded me of those toothpaste ads where the guy can't even find a job, can't do nothing! He's up the creek without a paddle for sure. And then some character sends him to his dentist who tells him to use Enamel-Scratch toothpaste, and right away he's president of the company with all the babes he wants. Nuts! It ain't as easy as that. This guy in the picture didn't get well just by listening to the doc a few days. He couldn't."

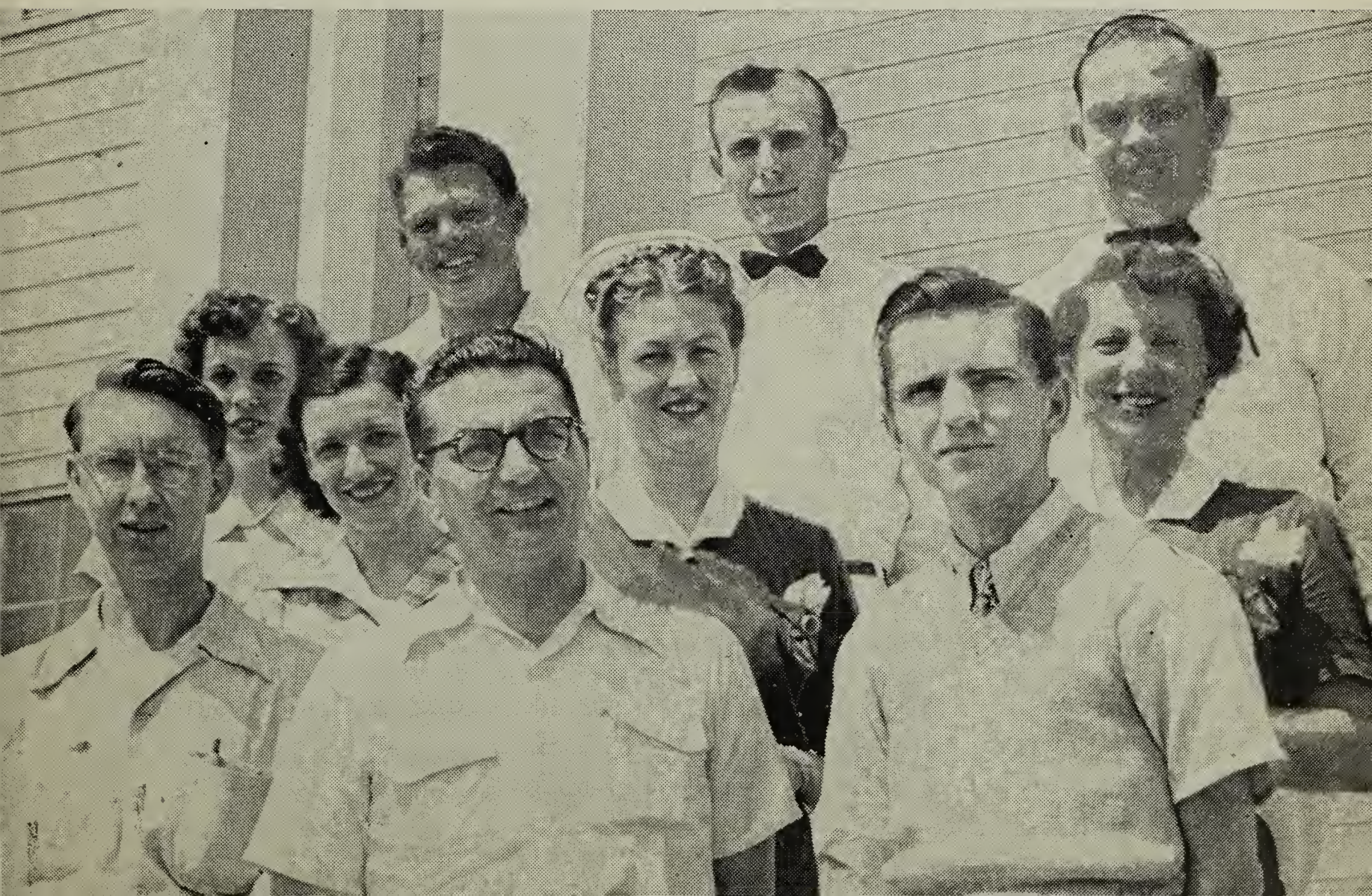
I could see that the other guys didn't like that guy. Yet there was something in what he said that appealed to me. Nobody said anything much until one of the boys with a slow drawl and the look of Texas written all over his six-feet-two-hundred pound frame said, "You're right, Jake. He didn't get well by having the doc talk to him. He got well by talking to the doc and by finding out about hisself for hisself. The doc just helped him. You ain't goin' to get nowhere unless you do some work for yourself."

Then somebody else put in his oar. The talk just kept going around and around. The doc will put in a bit and then ask someone what he

thought about it. Some of it didn't make any sense at all to me—words like "hostility" and "anxiety." But most of all I didn't see what they were trying to get at. Most of the time the doc said "scared" instead of "anxious" though, and I soon learned what that meant, just as "hostility" means "mad at somebody." But I still didn't see what it was all about or what possible good it could do me. I tried not to yawn. Then it was all over, and we were on our way in to lunch.

After lunch the man in white had me draw some pictures and told me that I would have to draw some more in five days. We were getting our vitamin shots every day to put back a lot of the stuff that liquor had taken out of us. In the afternoon we were free to go to the store or to the hospital or to play ball. In fact, we could do anything we wanted but buy a beer. We had to let the attendant know where we were going, of course, 'cause the doc sometimes came around to see us in the afternoon. Mail came in the afternoon and about noon, but there were no visitors.

The Butner Alcoholic Rehabilitation Center staff is shown on the front steps of the Center. Staff members on the first row are from left to right: Carl Ryerson, psychologist; Dr. Lorant Forizs, medical director; John Mendenhall, psychologist. Second row, Mrs. Charles Auman, secretary; Mrs. W. L. Cupp, secretary; Miss Elizabeth Alderman, occupational therapist; Miss Doris Boyd, occupational therapist. Third row, Attendants E. C. Keith, L. M. Holland, and J. W. Miller. Two staff members not present for the picture were Mrs. Marcus Wall, dining room hostess and E. L. Hoyle, attendant.



"RAISED THAT WAY"

As the first week went by, I began to see in those movies more and more of the way I had raised my own kids. I said a few words in the group discussions in the mornings. One day the doc asked me a question, "Why do you suppose you did those things to your kids?"

I thought for a minute. That was easy. "Why, because I was raised that way." From then on I was seeing my own raising in the movies. A lot of it was there. Dad wasn't ever worth much, and Mom had had to run things. When Dad would try to lick me, Mom would look out for me—most of the time. But Mom would sure see to it that I toed the mark. It was right after she died that I began drinking so heavily.

Things started getting confused about then. I could see from what the doc had said and what I had figured out that at least 50% of the trouble I had had with my mother-in-law was from not being able to appreciate the way my own mom ran my life. Yet I loved my mom. I got more and more confused as the time came for me to go home. I had seen those movies until I was blue in the face. At one time I thought I had it all doped out. Then I suddenly realized I was just kidding myself.

About this time some fellow came over and showed me some "ink blots." He said that they were to help the doc find out what was wrong with me, so he could help me better. The idea was to figure out what the blots looked like. I saw the screwiest things you could ever imagine in those cards. Then I had to draw a couple more pictures of people. They looked like nothing you ever saw before. I had never drawn a picture of a person before in my life, until I came here. The doc seemed pleased at what I had done, though. He must have been looking for something I couldn't see.

Then the day arrived when I went up for my interview with the doc. He asked me a lot of questions about what I had learned, and I asked him about a lot of stuff which wasn't too clear to me. I was scared by this time that I was going to break down again when I went home in two more days. Yet I knew that I had to try. Maybe I could make it—I surely would give it a chance. The doc helped me out a lot. He didn't give me all the answers by a long shot, but I felt a lot better after our talk. He wanted me to tie in with an AA group and gave me the address of one near home.

Then the day came. I packed my bag and stood on the porch, waiting for my wife and "Mother."

The big attendant and some of the boys came out.

"It's been nice knowing you, Mr. Doakes." He sounded like he meant it. "I wouldn't mind seeing you again, but I hope you don't need to come back here. If you do, you can come, you know."

"Thanks, fellow. I hope I don't have to, except maybe to visit."

Just then Betty pulled the car in. "Mother" was telling her how to drive, as usual. But somehow "Mother" looked a little different. Older, and a lot more tired. I almost felt sorry for the old girl. I knew I could never really warm up to her the way I had my own mom, but maybe we could get along now that I had stopped drinking.

Then it struck me. I had never admitted to myself before that I couldn't drink. I had never wanted to give it up completely. There was no half-way business about it. I smiled a bit, squared my shoulders and bent down to kiss my wife.

"Hello, baby. It's good to see you. Hello, Mother. Let's go home."

Something More . . . To Round Them Out

By our nature we alcoholics are extremists. This is no secret and it has often been said before. Half way measures are not our stock in trade. This can be dangerous in sobriety. We have to endeavor to live normal lives, and a normal life is a balanced life.

To do so we must bring into our life some substitute for drinking. We wasted time, money and life endlessly. Without drink everything seemed to be a vacuum. That time now must be filled. A great part of it, with many of us, goes in attending meetings, doing Twelfth Step work.

Something more, however, should come into our lives to round them out. An outside interest, a hobby, a sport. We should take an active interest in the affairs of our communities, the nation and the world. We should make our influence felt in all walks of life, not just within the four walls of the meeting room or the alcoholic ward.

It is possible to become narrow in outlook and action even in a worthy cause. It is possible to inbreed to a dangerous point. We must become normal persons with normal interests as well as the very special and predominating interest of AA. We must be a bridge for the universal ideas contained in the Twelve Steps and thus help others, not necessarily alcoholics, as well as ourselves to reach new goals.—From AA *Central Bulletin,* Cleveland, Ohio.

There Are Rules Fo

Like any hospital, Butner's Alcoholic Rehabilitation Center has its requirements for admission and its rules of conduct for all patients receiving the four-weeks treatment. As a guide for North Carolina citizens interested in Butner but "little informed" about its general policies, INVENTORY publishes here the formal requirements for admission to the ARC. Included is the letter of agreement which each patient signs on entering.

ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The requirements for admission to the Alcoholic Rehabilitation Center at Butner are:

1. The patient must bring with him, or have sent before his arrival here, a complete Social History. This history may be secured by the Superintendent of Public Welfare in the patient's county, or by the family physician. Either of these people has a copy of the Social History Outline. This Outline is not to be written on or used as an application blank. It is merely a list of the items about which we need information. The case worker should use the Social History Outline as a guide to follow in drafting the report, IN PARAGRAPH FORM, from the information supplied.
2. The patient must come of his own free will. On arrival, if he is accepted, he will be asked to sign the form of voluntary admission and agreement to abide by the rules.
3. The patient should bring, or have sent ahead of time, a letter of referral from his doctor. This letter should state that he is an alcoholic and should give details of the patient's treatment to date.
4. The patient must not be under the influence of alcohol. If he is, he cannot be admitted. Patients have been turned away because they were inebriated on arrival.
5. The cost of care and treatment is $72.00 for 28 days, payable in advance. No refund can be made.

Patients are admitted from 9:00 A.M. to 4:00 P.M. on Monday through Friday, and from 9:00 A.M. to 11:00 A.M. on Saturday.

No visitors are allowed in the Alcoholic Rehabilitation Center here.

For further information, the prospective patient, his family, his physician or minister, or any interested citizen can write the North Carolina Alcoholic Rehabilitation owce in Raleigh or the Alcoholic Rehabilitation Center office at Butner, N. C. Many needful men are failing to receive this service—not because they don't want it, but because they know little about it.

Admission and Conduct

To All Patients:

You came here because you felt that you needed help. All of you came of your own free will and none of you is committed to this institution against your will by formal order.

We all feel that your problems can be solved; and they can be solved if you realize that the key-figure in this is your own personality, and that it needs new adjustments.

Working with the Staff every one of you will have to get a better understanding of yourself. This will mean taking an inventory of emotional assets and liabilities.

It requires meditation, work within yourself and work with the staff of this institution. Experience with similar conditions shows that this can best be done if you are away from immediate contact with the outer world. Therefore, as a first step, visitors will not be admitted.

We also expect you to agree to the following rules:

1. To take no alcoholic beverages.
2. To take no drugs except as prescribed by the physician in charge.
3. To stay for four weeks.
4. To cooperate in work within and around the building in keeping the place neat and clean, and in assisting in serving the meals.
5. To comply with the rules, or to leave if requested by the physician in charge.
6. To be transferred for any acute medical or surgical condition to the Hospital ward at the State Hospital at Butner if advised by the physician in charge, who will visit on that ward. Or if you desire and are able you may be admitted to a general hospital at your own expense.
7. A patient who cannot or will not cooperate and comply with the rules will be asked to leave and no credit or refund will be made for the unused portion of money paid on admission.
8. A patient leaving with permission within the four weeks period is not entitled to any refund, but may be re-admitted within thirty days of leaving on the same application, and may remain the unused portion of his stay. If he does not return within thirty days, there will be no credit given.
9. A patient who has left without permission may return after the expiration of thirty days, and only upon a new application and a new payment of $72.00.
10. A patient who leaves twice on the same admission or on two successive admissions may not be re-admitted except after six months.

I have read and UNDERSTAND this and I hereby show my complete agreement to it with my signature.

Signature.....Date.....

"THEIR SIDE OF THE PICTURE"

Recently while reading the first issue of INVENTORY, a group of patients at the Butner Alcoholic Rehabilitation Center "got the idea" of giving a short word study of their "side of the picture."

The actual report was suggested by a member of the ARP staff after some of the men had spent nearly an hour after lunch one day talking of how well they liked the Center.

The staff member asked the patients if they would like to get a "general opinion of the place" from the whole body of patients currently receiving treatment.

The response was spontaneous, a committee was elected by the patients, and a report was voluntarily drawn up to answer some questions the average North Carolina citizen might have about the Center.

The following report represents the opinions and attitudes of men who are now patients at the Butner ARC—it came through a casual suggestion voluntarily offered and voluntarily accepted.

"At a called meeting of the patients of the Alcoholic Rehabilitation Center at Butner for the purpose of discussing general conditions at the Center, it was unanimously decided to appoint a committee of four to draw up the conclusions of the patients and present them to North Carolina's journal on alcohol and alcoholism, INVENTORY.

"The phases discussed were food, treatment, instruction and teaching of the doctors, freedom allowed the individual patient, and recreation.

"The food is well prepared, plentiful, and the menu prepared by a dietitian. The meals are served cafeteria style, and at night milk and juices are provided for all patients. The food is served by Mrs. Marcus Wall, the dining room hostess.

"The treatment is by vitamins and any other necessary medicine and by instruction given the group and individual patients by Dr. Lorant Forizs, medical director of the Center.

"Dr. Forizs uses the Socratic method of teaching, supplemented by moving pictures dealing with alcoholism, and included are group discussions and private consultation.

"When the patient arrives, he is provided a room with a comfortable bed, showers and toilet facilities. He is placed under no confinement and is put only upon his honor to obey the rules and regulations.

"There is a large recreation room and lounge with billiard table, ping pong table, combination radio, library, athletic equipment, coca cola machine, and 'everything' but a TV set.

"At any time the patient becomes dissatisfied he can leave. The attendants are selected and well qualified for their work. One is on duty at all times. The afternoons are devoted to recreation which includes walks, baseball, football, horseshoes, croquet, volley ball—all as the individual patient desires."

A BALANCE FOR THE PICTURE

To balance the opinions of the in-patients on the parallel page, INVENTORY is taking the liberty here of running a few remarks from patients who have been out of the Center for a number of months.

The following remarks were lifted from letters of former patients. They are given to clear up any idea that the in-patients were "forced" or "guided" into their remarks.

From *Mayodan,* a former patient writes: "Yes, my treatment has been very helpful to me."

From *Sylva,* there are two opinions: "Butner's a great help for an alcoholic, if he wants to help himself"—"The Program is grand. I certainly am glad I found it when I did."

From *Monroe,* deserved praise for the Center's medical director comes forth: "I think Dr. Forizs is doing an excellent job and the state is very fortunate in having a man of his ability in that position."

A former patient of *Hope Mills* sends words of suggestion and praise: "I know Butner is in its experimental stage, but they need something more to keep the men occupied, such as recreation or vocational therapy. But as for me the State has never started anything better. I hope it succeeds."

(Editor's note—The recreational and vocational therapy suggested by the Hope Mills patient is now being developed into a full program.)

Roxboro and *Siler City* patients speak of control: "I think it would help anyone that can't control himself"—"It is a fine place, and they will help you if you will help yourself."

From *Lumberton,* a former patient shows an interest in other problem drinkers: "I would like for you and all concerned to know that but for my stay at Butner I would not be sober today. You are hereby authorized to use this statement and my name in any way you see fit, if in so doing it will influence some other alcoholic into giving Butner a try at helping him."

A *High Point* man speaks of self-respect: "I'd like to say again that Butner helped me find my self-respect once again and that I'm beginning to live again."

In *Gastonia,* a patient is suggesting Butner to friends: "I have gotten so much from my stay in Butner that I'm telling about it, and to people who in turn need help. You just can't imagine how much I appreciate Butner."

From *Stanfield* comes mention of value received: "Yes, I received help, and it has already been worth more than it cost me."

A *Mooresville* citizen is ready for a good word "at any time": "I really did enjoy myself at Butner and I would not take anything for what I learned there . . . keep up the good work, and may God bless you all in this worthy cause that you are working for, to help and give men like our leaders the power to carry on this great work at Butner, and feel free at any time to call upon me for a good word for Butner."

Holding The Contact Through Letters And Questionnaires

Following up the patient or holding the contact made by the Butner Alcoholic Rehabilitation Center is one of the greatest problems facing the Program today.

Since the Butner Center is set up for voluntary admissions, all patients are accorded essentially the same privacy they might expect from any other hospital for any other illness. Their medical history and charts are confidential and available only to another physician who might be attending the patient.

This means that the ARP cannot use the services of public or private case work agencies in contacting discharged patients and in reporting their progress and condition to the Program's office. The ARP does write to the discharged patients and the physician who aided them in gaining admission to the Center.

These letters ask both the patient and the doctor to supply the ARP with all information relative to the patient's condition and progress. One month after the patient's discharge, he is sent the following letter and questionnaire:

Date.....

Dear Mr. .....:

You came to our Treatment Center at Butner of your own free will and voluntarily applied for admission. In doing this, you indicated a realization of your illness and a sincere desire to recover. We wish you to know that we respect your privacy and anonymity and that your records are strictly confidential. However, we are intensely interested in you and would like to know how you are getting along, and if we have made any contribution toward helping you understand your problem and recovering from your illness. In our attempt to keep up with you, we are writing directly to you and asking that you kindly complete the enclosed questionnaire and return it to our office.

May we once more encourage you to visit your nearest Alcoholic Anonymous Group and keep in touch with your family physician. Your doctor is also interested in you and would like to keep in touch with you.

In AA you will find sympathetic and understanding friends whose problems have been the same as yours and who are interested, not only in their own recovery, but likewise are interested in yours. Visit them; enjoy their friendship and lean upon them for support. You may be assured that you will find a welcome.

The address of your nearest AA group is.....

Sincerely,
S. K. Proctor

PATIENT'S QUESTIONNAIRE

1. What is your present permanent address?
2. Are you regularly employed?
3. Have you visited your Mental Hygiene Clinic?
4. Have you attended any AA meetings? ..... Regularly?
5. Have you been continuously sober since leaving Butner?
6. If not, how many slips have you had?
7. Of what duration were they?
8. Do you feel you received help at Butner and that your stay was worthwhile?
9. Have you any suggestions for or criticisms of the Butner Center?
10. If you have any criticisms or suggestions to make and do not wish to be identified, please drop me a note and leave it unsigned.

At the same time the following letter and questionnaire is sent to his physician:

Dear Dr. .....:

In recent weeks a patient of yours was discharged from our Treatment Center at Butner, N. C., and it is about this patient that we are writing you today.

Our Treatment Center at Butner accepts its patients on voluntary admission only—no court commitments—and as a consequence, in order to respect their anonymity and the confidential nature of their medical records, we cannot use the services of public case work agencies. We can write to his physician who recommended him for admission and we can write to the discharged patient. This we are doing in an effort to learn something about the patient's condition and behavior since leaving Butner. Only in this manner can we measure our accomplishments and determine the direction of future action.

You can aid us in our efforts to help these people by answering the enclosed questions as fully as possible and returning the questionnaire to this office.

Sincerely,
S. K. Proctor

DOCTOR'S QUESTIONNAIRE

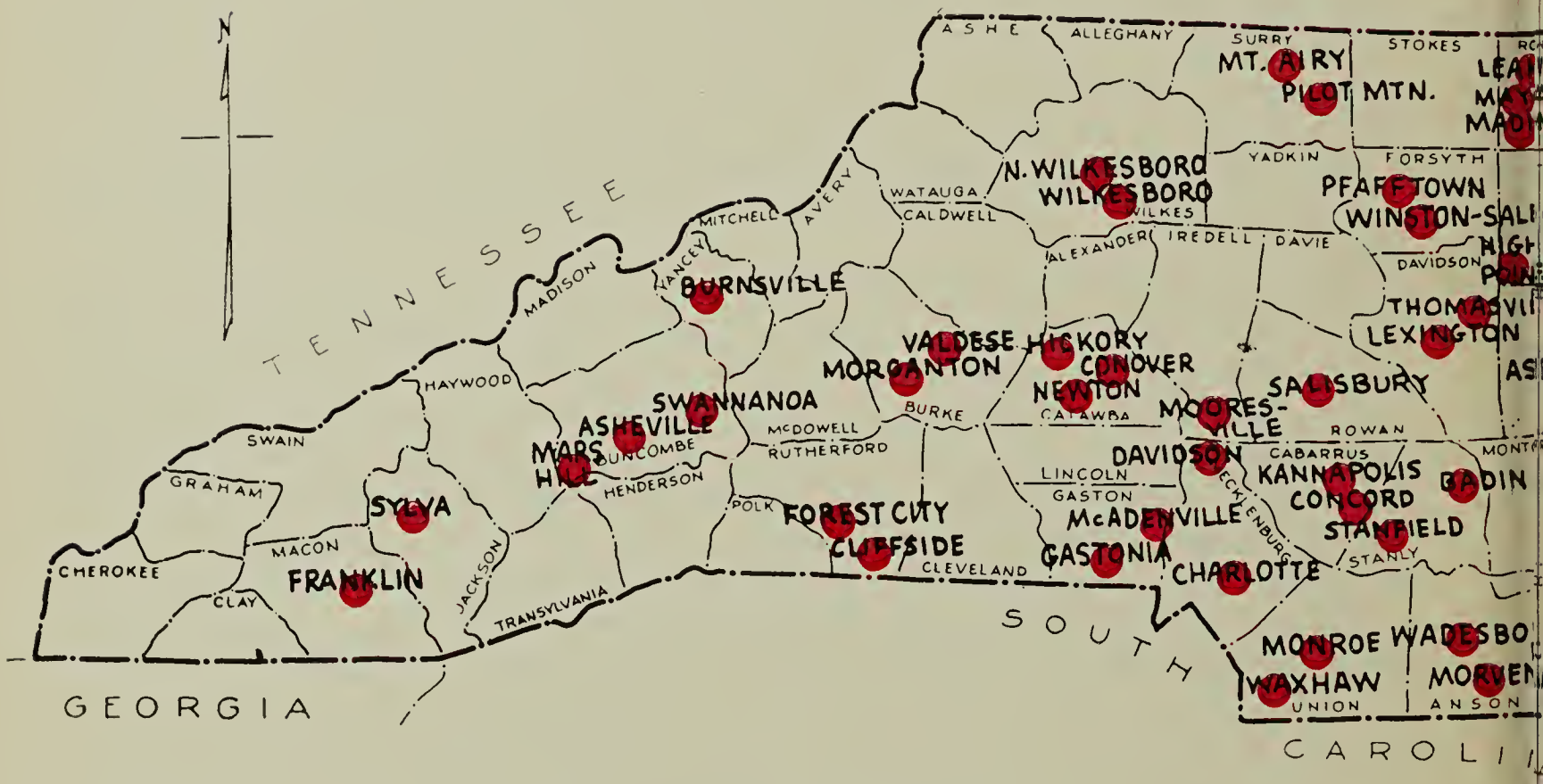
1. Have you seen this patient since his discharge from Butner?
2. Have you been called upon to provide professional aid to this man for intoxication or acute alcoholism since his return?
3. Have you received any reports that the patient is again drinking?
4. Has there been any change in frequency or severity of his drinking bouts?
5. Does there appear to be any improvement in his attitudes and social behavior?
6. In your opinion has the patient's experience at Butner benefited him?
7. Has the patient expressed any opinion regarding himself or the Center?

Careful record is kept in the ARP Raleigh offices of the questionnaires sent and those returned. A recap is made of the information, then the questionnaires are placed in the patient's file at Butner to become a part of his permanent chart.

A PANORAMA —

Where The Weak
And The Strong

"Here's to the land o
The summer land wher
Where the weak grow
And the strong grow
Here's to your home
The Old North State."

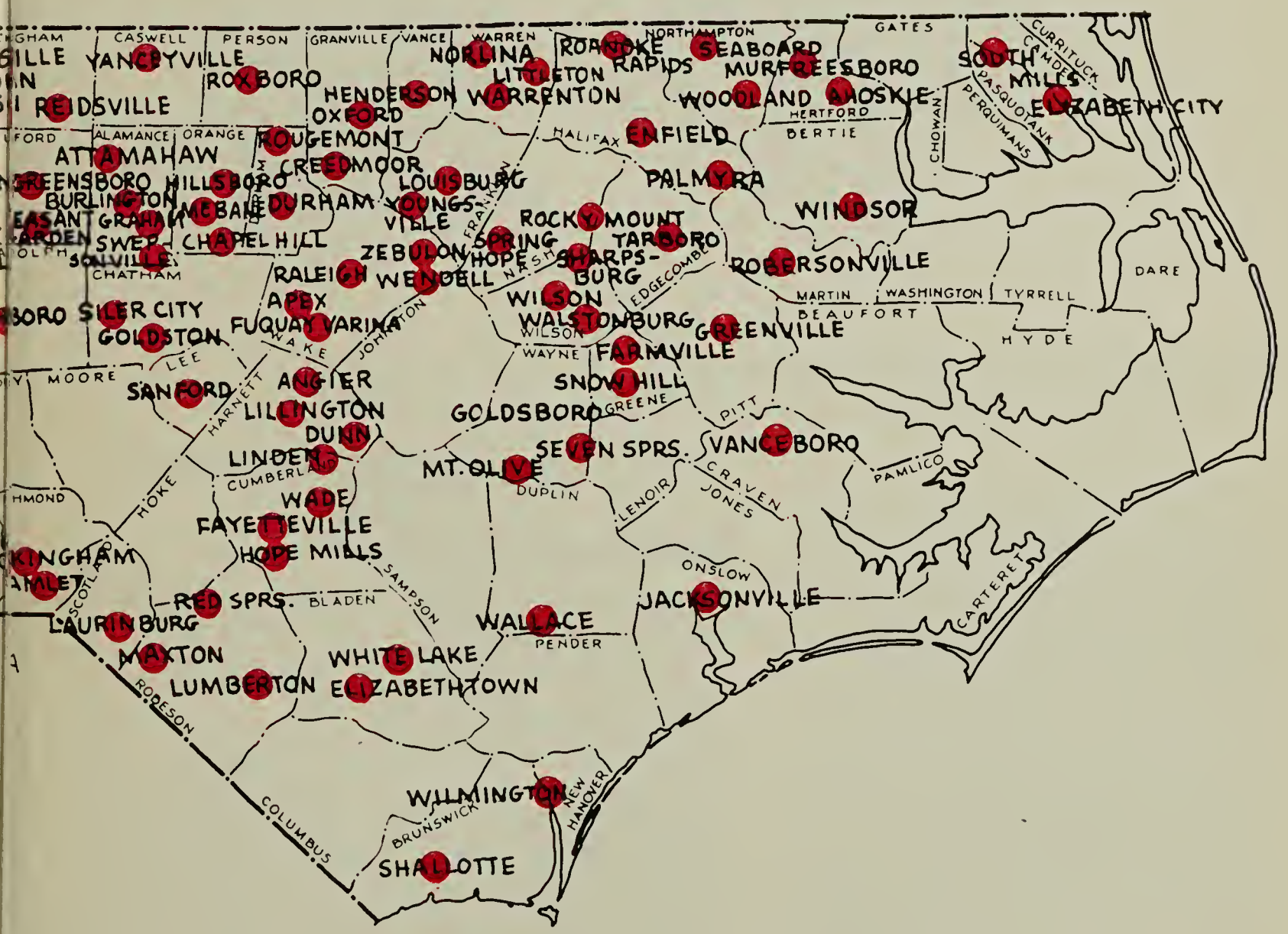


Here is a geographical panorama of the first ten month
Over 115 North Carolina towns and 63 counties have been
The response was slow, at first, until those who neede
is a "new day" in "State institutional" treatment of alcohol
corded.

f he long leaf pine
he sun doth shine:
s long
rat,

Can Grow Strong
Might Grow Great

VIRGINIA



dmissions to the Butner Alcoholic Rehabilitation Center.
presented at the Center since it opened last September.
t and those who were interested in it learned that Butner
n. By the last of June over 275 admissions had been re-

TAR HEEL PRESS

The Charlotte Observer

JOURNAL ON ALCOHOLISM.

SOMETHING new in the field of periodicals is an attractive little magazine called *Inventory*, which describes itself as "a bi-monthly journal on alcoho; and alcoholism." It is published by the North Carolina Alcoholic Rehabilitation Program, 357 Revenue Annex Building, Raleigh, and is edited by Santford Martin, Jr., educational director of that agency.

The name of the new publication derives from the idea behind it. "If we are to understand the illness of alcoholism, we must make an inventory of what we know and don't know about beverage alcohol and human personality," says the introductory editorial in the initial number. "Honest inventory should produce an educational approach with four aims to give scientific facts about alcohol and its problems, to eliminate prejudices that color the problems, to present alcoholism as an illness, to teach personal responsibility in all alcohol matters."

In a letter, Dr. David A. Young, general superintendent, North Carolina Hospitals Board of Control, writes: "We hope that this first issue of *Inventory* will be the forerunner of many, serving a very important purpose in communicating and in spreading information about the Alcoholic Rehabilitation Program among the many persons interested in it."

And S. K. Proctor, executive director of the program, says in a letter that the new journal "will serve as an informational organ through which to acquaint our people with the latest facts on alcohol and alcholism and the monthly progress of our alcoholic rehabilitation team. We like to think of this team as consisting of the physician and the psychologist, the minister and Alcoholics Anonymous, the social case worker and the sociologist."

The initial issue of *Inventory* is dedicated to the staff and patients of Butner Alcoholic Treatment Center, where scores of men have been treated since September, 1950, and "scores of successes have been registered."

Raleigh Associated Press Bureau

New Magazine On Alcoholism Issued

RALEIGH, May 9—(AP)—A new step in handling the problem of alcoholism has been taken with the issuance of a magazine on the subject.

The magazine, named "Inventory," will be published twice monthly by the North Carolina Alcoholic Rehabilitation Program sponsored by the State Hospitals Board of Control.

The lead editorial explains the title by saying that "If we are to understand the illness of alcoholism we must take an inventory of what we know and don't know about beverage alcohol and human personality."

An article by John S. Ruggles of Southern Pines, a member of the Hospitals Board of Control, asserts that alcoholism is a disease, that the alcoholic can be helped and that alcoholism is a public health problem and, therefore a public responsibility.

The article also says that North Carolina has approximately 12,000 chronic alcoholics and countless more problem drinkers or potential alcoholics.

S. K. Proctor is executive director of the alcoholic rehabilitation program, and Santford Martin, Jr., editor and educational director.

The magazine will go to about 7,500 citizens in the medical, ministerial and public service fields. Copies also will go to Alcoholics Anonymous groups, school and college libraries, newspapers and legislators.

WINSTON-SALEM JOURNAL

New Weapon in Old Fight

By H. Clay Ferree

At the end of his business year the merchant takes an inventory of his stock of goods and other assets. He carefully checks all the items in his stock to determine how many goods he has and what he will need in stock to start the new year.

In the new pioneering State Alcoholic Rehabilitation program the doctors and psychiatrists at the Butner center and in the hospitals make a similar inventory of alcoholics. They endeavor to find out all the pathological, psychological and historical facts concerning the patient, and try to determine what his assets and liabilities are, so to speak.

This fact gave Santford Martin Jr., the Winston-Salem man who is the educational director of the North Carolina Alcoholic Rehabilitation Program, an idea for the name of the new well-edited, well printed and highly interesting little bi-monthly magazine published in the interest of the educational phase of the program. So "Inventory" is the name of the periodical, the first issue of which (for May, 1951) has now been published.

The purpose of "Inventory" is to gather and present scientific facts about alcohol and its problems, to eliminate prejudices that color the problems, to present alcoholism as an illness, and to teach personal responsibility in all alcohol matters. It is designed to help the public, to whom alcoholism is an increasingly serious problem, to take inventory of all phases of the problem, and from the knowledge thus gathered, move to meet and master the problem in the most effective manner.

In a published letter to the editor, Governor W. Kerr Scott asserts:

"In issuing this journal on alcohol and alcoholism, the North Carolina Alcoholic Rehabilitation Program takes a pioneer step toward giving unbiased, scientific facts on this problem to those citizens who want such facts . . ."

Dr. David Young, general superintendent of the N. C. Hospitals Board of Control, expresses the belief that the publication will serve a very useful purpose in spreading information about the rehabilitation program.

S. K. Proctor executive director of ARP, states "The journal, Inventory, will serve as an informational organ through which to acquaint our people with the latest facts on alcohol and alcoholism and the monthly progress of our rehabilitation team. We like to think of this team as consisting of the physician, and the psychologist, the minister and Alcoholics Anonymous, the social case worker and the sociologist."

The first issue of "Inventory" appears in attractive format and carries several interesting and informative articles, some explaining the State rehabilitation program and others dealing with the nature of alcoholism and the problems involved in dealing. The initial issue is dedicated to the staff and patients of the Butner Alcoholic Treatment Center. "For all these sick but brave men," it says of the Butner center patients, "this educational journal is created in the hope it will throw needed light on a vital health problem too long unsolved by provincial stigmas."

If the succeeding issues of "Inventory" live up to the promise of the first, it will indeed "throw much light" and accomplish much good in the fight against one of man's and society's worst enemies—alcoholism.

THE CLEVELAND TIMES

A Part Of The Life Of Cleveland County

SHELBY, N. C.,

Congratulations To A Pioneer

"If we are to understand the illness of alcoholism, we must take an inventory of what we know and don't know about beverage alcohol and human personality."

With those words was launched this month "Inventory", a bi-monthly educational journal on alcohol and alcoholism, the pioneer in its field and published by the North Carolina Alcoholic Rehabilitation Program.

The journal itself might well prove an historic step in the ultimate control of a problem which ante-dates history and which until these recent years has remained unattainable for a number of reason, foremost among which were: the stubborn attitude that alcoholism was a moral delinquency, rather than a personality disease, of which moral delinquency is often a symptom; and, the lack of general interest in compiling and publicizing helpful research and successful methods of treatment, as though the patients were hopeless derelicts.

"Inventory" is an answer to these two previous failures—and others—in our efforts to control alcoholism and rehabilitate alcholics, as we control tuberculosis and rehabilitate its victims. It should awaken wider and wider interest of a public character in this vital social problem and instill in an ever widening circle a clearer and more constructive understanding of that problem.

"Inventory" is a challenge, too. There is a sense of personal responsibility which must be restored in the alcoholic before he can be made a whole man again. There is a sense of fraternal responsibility which must be instilled in society before we can achieve the degree of success in alcholic rehabilitation which is possible.

As "Inventory" points out on the first page of its first issue: "Perhaps society would do well to take an inventory of its own collective personality, analyzing its traditional attitudes plus or versus its current actions. In contrast to the 5% considered curable only yesteryear, today's pioneer alcoholic clinics report 60 to 80% arrested cases."

We wish the years of successful influence for "Inventory" may never end—until with the cooperation of us, all, it has accomplished its mission.

VIEWS INVENTORY

"Alcoholism Is a Disease," N. C. Rehabilitation Credo

The first edition of *Inventory* is well done. It contains some of the objectives of the program directed by S. K. Proctor and having Mr. Martin as its educational director. It features several articles on the nature of alcoholism and maintains a highly objective approach and remains scientifically aloof from any hints of pro and con prohibitionist controversy.

Martin, as editor of *Inventory*, outlines the aims of the educational program, as follows

1. To give scientific facts about alcohol and its problems.

2 To eliminate prejudices that color the problems.

3 To present alcoholism as an illness

4. To teach personal responsibility in all alcohol matters.

Many people still dispute the fact announced by competent medical experts that alcoholism is a disease.

In its first edition, *Inventory* positively affirms the credo that alcoholics are sick people—persons suffering from a disease. Dr. John S. Ruggles, Chairman of the Alcoholic Committee of the N. C. Hospitals Board of Control, states: "The fact that alcoholism is a disease is not a new discovery . . . yet the conception of alcoholism as a disease is still news to many . . . This pioneer journal on alcohol and alcoholism in North Carolina should make such news a reality."

Twin City Sentinel

The Weekly Gleaner Est. 1870 — Western Sentinel Est. 1856
Farmers Reporter Est. 1912 — Winston Leader Est. 1879
The People's Press Est. 1851 — Twin City Daily Est. 1885

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MEMBER OF THE ASSOCIATED PRESS

GREENSBORO DAILY NEWS

An Effective Organ

A new periodical to come to the Daily News editorial desk is "Inventory," published by the North Carolina Alcoholic Rehabilitation Program, operated by the State Hospitals Board of Control, and edited by Santford Martin, Jr.

The purpose of the new publication, which has an attractive format and excellent typographical appearance, is symbolized in its title. "If we are to understand the illness of alcoholism," says a statement by the editor in Vol. I, No. 1, "we must take an inventory of what we know and don't know about beverage alcohol and human personality. Governor Scott, Dr. David A. Young, general superintendent of the North Carolina Hospitals Board of Control, and S. K. Proctor, executive director of the program, stress the same purpose, the problems involved and the necessity for teamwork and understanding if these problems are to be solved.

The magazine should serve to helpful and constructive purpose as the organ of the program of which it is a part and as a contribution to education and the sense of personal responsibility which are essential to intelligent and effective treatment of alcoholism as it concerns the individual victim and society. It took North Carolina a considerable time to get around to this reasonable, scientific approach; but now that it has, beneficial results can be expected. The rehabilitation center at Butner is already having its effects; results of the educational campaign will necessarily be slower and accretional. It is quite proper that the initial issue of Inventory should pay merited tribute to those who did most to make this new program a reality, Representative John W. Umstead, Frank M. Kirkpatrick and H. C. Blue who co-sponsored the legislation which made it possible, and John S. Ruggles, chairman of the hospitals board's Alcoholic Committee, who worked unceasingly to get the program going.

BIBLICAL RECORDER

Journal of the Baptist State Convention of North Carolina
Founded 1833, by Thomas Meredith

WE HAVE JUST RECEIVED the first issue of *Inventory*, a bi-monthly journal on alcohol and alcoholism, published by the North Carolina Alcoholic Rehabilitation Program and edited by Santford Martin, Jr.

The publication begins as a small 32 page magazine

An explanation of the title and reasons for the publication may be seen in the opening paragraphs of an editorial on the subject, "Inventory—A Necessity"

"If we are to understand the illness of alcoholism, we must take an inventory of what we know and don't know about beverage alcohol and human personality

"Honest inventory should produce an educational approach with four aims: to give scientific facts about alcohol and its problems, to eliminate prejudices that color the problems, to present alcoholism as an illness, to teach personal responsibility in all alcohol matters

"A recognized step in arresting alcoholism is the personal inventory a problem drinker finally takes of himself, led by his physician, often by Alcoholics Anonymous or a minister, occasionally by his family or a close friend. The drama of excuses is at first a painful ordeal, until the fog of alcoholism gives way to the truth"

GASTONIA GAZETTE

Education On Alcoholism

One of the more recent publications to come to the editor's desk is one which bears the title "Inventory" It is a publication of the North Carolina Alcoholic Rehabilitation Program. This program is operated by the State Hospitals Board of Control

Following is a statement as to the purpose of the publication as made by the editor in this first issue

"If we are to understand the illness of alcoholism," says a statement by the editor in Vol. I, No. 1, "we must take an inventory of what we know and don't know about beverage alcohol and human personality. Honest inventory should produce an educational approach with four aims: To give scientific facts about alcohol and its problems, to eliminate prejudices that color the problems, to present alcoholism as an illness, to teach personal responsibility in all alcohol matters"

This publication should contribute constructively to the education of the public along these lines We suggest that the public schools offer one of the most fertile fields for the dissemination of its teachings. Especially so since, we understand, the textbooks on physiology no longer teach the pupils of the ill effects of liquor on the human system It should be placed in the hands of public school teachers and pupils alike.

North Carolina Medical Journal

Owned and published by
The Medical Society of the State of North Carolina,
under the direction of its Editorial Board.

NORTH CAROLINA ALCOHOLIC REHABILITATION PROGRAM

The first edition of a bi-monthly journal on alcohol and alcoholism was issued the first week in May by the North Carolina Alcoholic Rehabilitation Program, S. K. Proctor, executive director, announced recently. The pocket-size journal has been named Inventory, a title explained in the lead editorial of the first issue, and will feature a variety of articles adapted for general and specialized readers alike.

Progress and development in the North Carolina program will be featured with news from other programs over the nation, including special Yale University articles on the latest findings in alcohol and related problems.

Edited by ARP educational director, Santford Martin, Jr., the magazine will open circulation to 6,000 citizens in the medical, ministerial, and public service fields. It will also go to state Alcoholics Anonymous groups, high school and college libraries, news and legislative officials.

Editorial and circulation offices are in the ARP Raleigh office at 357 Revenue Building Annex.

"ONE OF THE MOST UNUSUAL COURSES . . .

Tar Heel Citizens Become Yale Students During Summer Course

Last March the following public announcement was made through North Carolina newspapers and radio stations:

"Twenty scholarships to the 1951 Yale University Summer School of Alcohol Studies are now available to North Carolina teachers, health officers, social workers, ministers, personnel workers, law enforcement-correction officials, and Salvation Army workers.

"Sponsored by the state Alcoholic Rehabilitation Program, the special educational grants include tuition, room and board, and partial travel expenses. Only Sunday meals are not included in the scholarship.

"Applications for the special scholarship must be submitted to the Raleigh office of the ARP by April 27 and should include a statement of professional background and any particular interest in newly discovered facts and problems relative to alcohol and the illness of alcoholism."

Scores Of Applications

By the last week in April, the Raleigh office had scores of applications from which to choose qualified students for the Yale School. The job of selecting was a challenge to honest objectivity, and every effort was made to recognize and accept each application on the basis of its qualifications.

The following twenty North Carolina citizens were granted the special scholarships and are now on their way to Yale:

Robert L. Denny, Vocational Rehabilitation Counselor, 201 Owen Building, Salisbury; Rev. Harold D. Hayward, minister of the Providence Presbyterian Church, Route 1, Matthews; Miss Mary Ruth Davis, public health nurse of Greensboro, Robbins; Rev. Harry C. Hubbard, Baptist Chaplain, Veterans Administration Hospital, Oteen; Miss Lillian C. Hunt, Executive Director of the Durham Y.W.C.A., Durham.

Representative Areas Included

C. M. McCall, principal of Spaulding-Monroe High School, Bladenboro; Rev. Joseph R. Bogle, minister of St. Paul's Methodist Church, Asheville; Mrs. Louise P. Cornett, public health nurse of Avery County, Newland; Miss Jane F. Latham, case worker of the Mecklenburg

County Department of Public Welfare, Charlotte; Mr. C. Bruce Hunter, Sr., teacher, 25 Warwick Road, Asheville.

Mrs. H. H. Strickland, teacher, Kinston; Judson R. Dicks, classroom supervisor Army Education Center of Fort Bragg, Fayetteville; Kenneth F. Jerkins, high school teacher, Scotland Neck; Rev. Harold Roland, minister of Mt. Gilead Baptist Church, Durham; Miss Jinsie Underwood, Director of Social Science, Gastonia High School, Gastonia; Rev. Samuel M. Houck, minister of Concord Presbyterian Church, Loray; David S. Cox, Jr., salesman, 201 Chamberlain Street, Raleigh.

Variety Of Professions Attending

Rev. Wendell R. Grigg, minister of Southside Baptist Church, Winston-Salem; Miss Dorothy D. Ennis, psychometrist with the Veterans Administration at the Greensboro Evening College, Greensboro; Rev. James Wiley Fowler, Jr., pastor First Methodist Church, 417 East Main Street, Forest City. In addition, three members of the ARP staff are planning to attend the Summer School: Dr. Lorant Forizs, ARP medical director; S. W. Martin, ARP educational director; and Charles L. Auman, Butner social worker.

Origin Of The Unique School

The unique Yale summer session originated in 1943 under the eminent writer and authority on alcohol, Dr. E. M. Jellinek, now Dean of the Institute of Alcohol Studies in the Southwest at Texas Christian University. Today the School is directed by Dr. Selden D. Bacon, associate professor of sociology and chairman of the Connecticut Commission on Alcoholism.

Once called "one of the most unusual courses in the history of American education" by a national news magazine, the Yale School of Alcohol Studies runs from July 7 through August 3 and presents the most recent findings of scientific research available for application to the problems of alcohol in the community.

Registration was set for Saturday and Sunday, July 7 and 8, with the first lecture and reception planned for the night of July 8. Dr. Howard W. Haggard, Director of the Yale Laboratory of Applied Physiology, will be the initial speaker.

This Year's Emphasis

Director Bacon recently stated this year's emphasis: "In view of current problems of defense and industrial manpower, somewhat greater emphasis will be placed on the problem of control and on

problems in industry than has been the case in previous years.

According to the Yale University News Bureau, "The Summer School's educational program is arranged to meet the needs of men and women in professions and activities requiring a thorough knowledge of the facts about alcohol problems."

The North Carolina scholarships were granted to people qualified to advance our state program of alcoholic rehabilitation and alcohol education. The new facts these citizen-students secure from Yale will be given to the public through speaking, teaching and other methods of sharing information.

Latest Alcohol Findings

Recognized nationally as the clearing house for all developments in alcohol problems, the Yale Laboratory of Applied Physiology is the only scientific organization devoting its time to such study and is able to give students the latest findings on alcohol.

Offering 62 lectures and 15 seminar hours, the School's curriculum includes four chronological phases-divisions: scientific orientation toward alcohol problems; relation of physiology, psychology, and cultural sociology to alcoholic beverages; the major problem areas; description and analysis of responses to these problems.

Included with this are informal group meetings, visits to the Laboratory, clinical and other facilities, and individual consultations with staff members.

Vital Inter-Student Contact

"Individual and informal group discussion or consultation with staff members is emphasized," Yale officials point out. "The diverse areas of interest, residence, experience and personal background represented by the student body make the inter-student contact a most valuable function of the school."

General subject matter includes medical study of therapeutic drugs, new techniques of traffic enforcement, religious counselling, high school teaching, and policy in industrial personnel work.

Representative Lecture Topics

Representative lecture topics cover the alcoholic, drinking as a folkway, the alcoholic pattern, wine and the Bible, college drinking patterns, inebriety and marriage, alcohol and crime, attitudes on alcohol, history of the temperance movement, the church and the alcohol problem, formal education and alcohol, and the public clinic approach to alcoholism.

Included are further studies in the development of personality,

alcoholism and the medical profession, alcoholism in industry, nutrition and the diseases of alcoholism, the alcoholic woman, Alcoholics Anonymous, alcoholism and mental health, and mobilization of community resources.

Growth In Eight Years

In the past eight years, the Summer School has been attended by 1,168 students from every state in the Union, the District of Columbia, nine Canadian provinces, and nine other nations in Central and South America, Europe and the Orient. A constant rise in the number of students with professional background is noted, namely, physicians, psychologists, educators, and persons in rehabilitation work.

According to the Yale record, "executive directors of alcoholism commissions in Alabama, New Hampshire, *North Carolina,* Ohio, Oregon, Utah, Wisconsin and Ontario are graduates of the School, as are directors of clinics for alcoholism in cities such as Buffalo, Detroit, Fort Worth, Milwaukee, New Haven, Pittsburg, and Rochester."

Increase In Educators

Though the number of attending ministers and professional temperance workers has declined, attendance by educators has increased until they represent the largest single group in the student body. State departments of education have had representatives in every session, with high school and college health and physical education departments being most widely represented.

Although Yale issues a certificate to those attending the session, academic credit must be obtained through the institution with which the student is registered. According to the School's catalogue, "In the past it has been usual for applicants to be granted such credits."

A New Attitude

A new and highly interesting attitude toward alcohol seems to be arising within society.

Basically it contends that most alcohol-related problems might be solved through the personal responsibility each citizen learns to take toward alcohol.

Such responsibility doesn't just happen. It is born of honest education based on fearless scientific truth. Such education also doesn't just happen.

It requires a penetrating analysis and presentation of three major areas: The make-up of alcohol itself, the effect of alcohol upon the human body, and the relationship of beverage alcohol and human personality.

Steps Toward A

There is no "typical alcoholic." There may be some typical traits. But each case is a separate personality, varying slightly or greatly. No one case possesses all the symptoms and danger signals.

Likewise there seems to be no "typical road" to alcoholism, though three major factors determine the status of any person using alcohol: Why does he drink? How much does he drink? How often does he drink? These elements of motive, quantity, and frequency are fundamental in determining and analyzing the problem drinker.

The confirmed alcoholic differs from the moderate drinker, the habitual drinker, and even the consistently heavy drinker. According to Yale authorities, a chronic alcoholic is a drinker who has developed a bodily or mental disorder as definite result of many years of heavy drinking.

Alcoholism is medically recognized as a chronic progressive illness of unknown cause characterized by abnormal drinking or uncontrolled use of alcoholic beverages.

In recent years, Dr. E. M. Jellinek, one of the creators of the Yale University Summer School of Alcohol Studies and now Dean of the Institute of Alcohol Studies in the Southwest at Texas Christian University, investigated the order in which alcoholism seems to overtake a person.

In this study, which was published in Yale's Quarterly Journal of Studies on Alcohol, Jellinek was helped by scores of Alcoholics Anonymous members who answered frankly all questions relative to their history.

A Well-Marked Road

Although research continues to probe new evidence, the road to alcoholism seems well marked by certain common experiences.

Three-quarters of the patients had been drunk before their twentieth birthday, while ninety per-cent began serious drinking on week-end bouts at "parties."

Then came the first *black-out,* the inability to remember actions after a certain point. This was followed by *sneak drinks* during which the subject downed a few early, quick ones to get an edge on the "party." According to Jellinek, the black-out and the sneak drink are pre-alcoholic symptoms.

Say, at 25, the week-end bouts begin. At 27, the drinker always winds up drunk. He can still control the occasions of drinking but not the amount. *Lack of control* "sets the definite course for alcoholism."

Decline of control brings *rabid rationalizing.* He seeks reasons for his heavy drinking, reasons he can always seem to find. Slightly resentful, sometimes belligerent and anti-social, he may pick an argument, a fight, and assert his "manhood."

At 30, he seeks the *eye-opener,* the morning drink which becomes a necessary means of starting the day. One to three years is the usual gap between the "eye-opener" and the genuine *bender.* This bout usually lasts for days

and takes him from "family, work, and other duties."

With the bender comes a new step, the acute or *compulsive* stage of alcoholism, in which control over the occasions of drinking is lost with control over the amounts.

Solitary drinking comes with these twin losses of control, accompanied by social isolation, losses of job, promotions, and friends.

Just before or in the bender stage, two prominent symptoms arise: *the water wagon* resolutions, and the *change of pattern* resolutions. The sufferer sees briefly the dangers of his condition and resolves to quit drinking.

If he falls "off the wagon," he will resolve to change the pattern, maybe shift to beer, change the time of day, anything to get out of the rut. But the resolutions are not as strong as his illness.

At 31, he experiences *persistent remorse* over his condition. Former rationalizations cave in, and three more symptoms pop up: frantic protection of his *source of supply, indefinable fears,* and *tremors* of his lips and hands.

For several years, this phase of drinking continues. Then *unreasonable resentments* begin to replace the feelings of remorse, as he grows steadily irresponsible, utterly egocentric. He becomes resentful of anyone, everyone who disagrees with him, and bout after bout drives him toward *geographic escape.*

He is now in the chronic stage of alcoholism. By 35, his physical health and anxiety have caused him to seek a doctor. Maybe a year later he seeks his minister or priest for spiritual aid.

Reaching The "Lowest Point"

According to Jellinek, the search for religious assistance may mean the sufferer's crutch of rationalization has failed him, no longer affords him "sufficient support."

At 37 to 40, he finally admits his failure with alcohol. Ten to twelve years he existed with no control over his drinking, but would never admit it. When he finally admits what others have seen and known, he is ready for Alcoholics Anonymous or other agencies of help.

This admission of no power over alcohol may be his "lowest point," if he actually quits. If he continues drinking, that point may come two or three years later.

The "lowest point" varies with the individual. For some, it comes when they face their hungry children, for others in the shadows of an early morning jail, for some in the "psycho" ward of a county hospital.

Whatever the stimulant, the man knows he is low, about as low as he can get.

This is not a "sure-fire" scale of measurement, though it does point up certain lessons. It warns that *week-end bouts, black-outs, sneak drinks* are signs of times to come. It warns that need of the *water wagon, plan for pattern changes* in drinking are all danger signals on the path to inebriety.

Some General Hospitals Pioneer In Accepting Problem Drinkers

A large number of general hospitals in North Carolina do not accept alcoholic patients for reasons of policy or specialization or inadequate facilities, according to a recent survey.

Policy is the predominant factor—policy of the board, or the medical staff, or the administration, or of all three combined.

North Carolina is not unique in such nonacceptance. Only in recent years have some leading hospitals of the East and North opened special floors or wards for the specific treatment of patients suffering from alcoholism.

Is It Worth It?

Some early leaders have been Knickerbocker Hospital in New York City, St. Luke's and Episcopal hospitals in Philadelphia, and Norton Memorial Infirmary in Louisville, Kentucky.

Four questions often stand in the way of any changes the average general hospital might make in its policy toward the problem drinker:

Are alcoholics obstreperous, obnoxious, aggressive, and generally uncooperative patients? Are alcoholics bad financial risks? Is the cost of operating such a facility greater than that for other services and does it require much more personnel? And does the acceptance of alcoholics create an undersirable reputation?

To The Source Of Experience

For the answer to such questions, the state ARP office recently went to the source of experience, some of the early leaders in the East and North and the Medical College of Virginia.

In New York, the famed Alcoholic Pavilion at Knickerbocker Hospital was formally opened in 1945, its services becoming an integral part of the hospital's medical service in 1947. Administrator. L. B. Dana reports patients generally offer no disciplinary problem, though persons in delirium tremens or acute stages of alcoholism are not admitted.

Knickerbocker requires advance cash payment on all admissions. Since all patients are recommended and accompanied by an Alcoholics Anonymous who remains on the floor until the patient is quiet, the

cost of operating the unit is far less than a general floor. Most routine duties, serving trays and odd jobs, are handled by the patients.

"A Deep Understanding" Of Foibles

Much of the success is due to the nurses who have "a deep understanding of the men's foibles." Dana feels that Knickerbocker has not become known exclusively for its alcoholic ward, though it has treated over 5,000 alcoholic patients since 1945.

St. Luke's Hospital of Philadelphia reports alcoholics are usually cooperative, especially when cared for in a separate wing or building. Some arrive in a belligerent mood, but become amenable through the sympathetic understanding of the clinic staff, according to Dr. Charles Seltzer, Jr., president of the hospital.

"We have found as a rule the alcoholic is as good a financial risk as any other patient that comes to the hospital," he adds. "Far from being unable to pay their way, as many people would assume, fewer alcoholics request or get free payment than the Board of Trustees was willing to allow."

"A Cardinal Principle" Toward Recovery

Advanced payment is requested, though some exceptions are made when money may be in a savings account or the patient may be able to pay over a given time. The assumption of financial responsibility is a "cardinal principle in the recovery program," according to Dr. Seltzer.

In an 18-bed clinic, St. Luke reports salaries and food the two major items of cost. Personnel consists of a business manager, a combined office manager and assistant nurse, a registered nurse, seven Navy corpsmen, one secretary, one technician, one kitchen maid, one combined kitchen helper and housekeeping helper, one full-time housekeeping maid, also one internist, one neuropsychiatrist, a pathologist, and a medical director.

"The Greatest Good Will Builder"

Regarding reputation, Dr. Seltzer has found work with alcoholics "the greatest good will builder." He adds, "Adoption of this program for alcoholics has made us unique among the hospitals of the city."

In Louisville, Kentucky, the Norton Memorial Infirmary operates an alcoholic unit "primarily for the benefit of persons who recognize

they have an alcoholic problem and wish to do something about it."

Through careful screening, credits and losses are at a minimum, with alcoholic losses less than 1% above that in the hospital as a whole. Though they operate on a cash basis, credit is extended persons sincerely trying to do something about their illness, and the risk is no greater than with a person who uses complete earnings in daily living only to become ill from an acute condition but with no money.

"Actually Less Trying And Lighter"

Norton has to pay a premium for nurses in the alcoholic unit, though the work is "actually less trying and lighter than on surgical and medical floors." A. C. Cunningham, lay director of the alcoholic program, traces this extra expense to the "misconception of the public, medical and nursing professions, in the handling of alcoholics."

Of further operational costs, Norton administrator, A. E. Hardgrove, reveals, "The manner in which the unit is operated determines the cost. I have visited units which are operated at a much lower cost than our own." Daily rates include medical service, therapeutic measures, pharmaceuticals, and foods for the intensive 5-day treatment.

"In No Way . . . A Handicap"

Norton patients develop real appetites from the treatment, nearly doubling the food amounts used by the regular patrons. Hardgrove has found that "if a high quality of service is rendered, the public is willing to pay the cost."

In no way has the alcoholic program been a handicap to the reputation of the hospital, for it has been accepted by the medical profession of the Louisville community and has "contributed tremendously to the services of this hospital."

Dr. Lucius R. Wilson, director of the University of Pennsylvania Episcopal Hospital in Philadelphia, declares, "I see no reasons why general hospitals should not participate in this program. Our hospital has cooperated with Alcoholics Anonymous and our experience has been very satisfactory.

Have Doctors "Who Understand"

"The important thing is to have physicians who understand the treatment of alcoholism if good results are to be obtained. In our arrangement we supply the medical treatment and Alcoholics Anonymous carries on after the patient leaves the hospital."

Only two alcoholics out of hundreds have given Episcopal Hospital any trouble, and the cost of treatment is no more expensive than with general medical patients and "less expensive than the treatment of many patients with serious illness."

In addition to their program being financially underwritten at $10.00 daily by A.A., Episcopal has found the families of alcoholics willing to meet any expense toward arresting the illness of their loved ones.

"A Very Progressive Step"

As to reputation, Dr. Wilson emphasizes, "In our own instance, the acceptance of chronic alcoholics for treatment in this hospital was heralded as a very progressive step and so far as I know we have never been criticized in any way for caring for such patients."

Selecting their patients very carefully, the Medical College of Virginia reports "alcoholics give no more trouble than patients on many of the other services." Since the stay on the alcoholic wing is relatively short, out-patient visit is emphasized as strongly as hospitalization, Director C. P. Caldwell reports.

Like many other institutions, the Virginia plan admits acute conditions through the emergency entrance and directly to the alcoholic unit without contacting the balance of the hospital.

Operating Costs In Virginia

Operating costs in Virginia amount to "little more than one per patient day cost," or $12.77 a day, or the state Alcoholic Studies and Rehabilitation Service is billed at the rate of $13.06 per day per patient. Actually, the Virginia General Assembly set up a rehabilitation program for charge at cost which underwrites all hospital costs, though many patients pay full and others part cost.

Director Caldwell concludes, "I do not recall hearing anyone say, certainly not in the past year, that the inclusion of an alcoholic unit in a general hospital was undesirable." Much favorable publicity of state and national level has come to the Virginia program.

Acceptance of the alcoholic as a sick person has grown more in the past decade than in any five previous decades. Necessary evidence can be found in the pioneering Quarterly Journals of Studies on Alcohol published by Yale University.

The Dawn Of New Attitudes

Representing the studies of objective specialists, the Journals are

full of remarks like these: "Because he is a sick individual, the alcoholic should be treated as a sick individual, regardless of repeated slips."

"Short-term hospitalization of the alcoholic, when coordinated with long-term follow-up, is capable of helping many of these unfortunate individuals to arrest their disease."

"The lurid, melodramatic 'curse of drink', which was played up in a former generation, has a better slogan in the 'cure of drink' today."

"A Problem" For Physicians

"Alcoholics, often sick or abnormal persons whose abuse is dependent on a faulty development or constitution or disease of some kind, or who have become abnormal or sick through the abuse, need the attention of specialists with analytical and therapeutic facilities."

"The alcoholic is a sick person whether his accompanying physical or emotional disabilities are causes or results of alcohol addiction."

"He is a problem for the medical profession simply because he is a sick person." —THE EDITOR

FUTURE FARE

Ready for the September INVENTORY are the following interesting features:

The Little Doctor Who Loved Drunks—Inspiring story of the late Dr. William Duncan Silkworth, an American physician who contacted 51,000 alcoholics in his lifetime and who was an inspiring "flame" to the early embers of Alcoholics Anonymous—from a recent *A. A. Grapevine,* the international monthly of Alcoholics Anonymous, by special permission of the editor.

Emotions and Biochemical Findings in Chronic Alcoholism—Discussion of Dr. Oskar Diethelm's study on this subject by Dr. James J. Smith, Department of Medicine, New York University - Bellevue Center —through special permission of Dr. Smith.

Public Health Program Against Alcoholism—As recently outlined by the World Health Organization of the United Nations Office at Geneva, Switzerland, "to treat alcoholism on medical lines . . . different from the approach of lay reform groups . . . not to be confused with political and social action against alcohol"—Secured through special press release from WHO's Geneva office.

An Anonymous Letter—On the subject "Alcoholism and Institutionalism" which appeared in A Citizens Committee Report on Alcoholism in Kansas City, Missouri.

CALLED PSYCHODRAMA

"Role Playing" Offers Effective Treatment For Problem Drinkers

The shortage of medical and other professional personnel required for the treatment of large numbers of alcoholic patients gives special importance to the development of techniques of group therapy.

Psychodrama, to which Dunton and Licht devoted one-fourth of their new volume on occupational therapy, has recently been tried with good effect in two groups of alcoholics.

S. Haber, A. Paley and A. S. Block describe the technique of "role playing" as applied at the Winter Veterans Administration Hospital in Topeka. A situation is chosen for enactment and roles are assigned to particular patients and personnel.

Deal With Real Problems

The situations are aimed at three goals: (1) To help patients deal with reality problems. Example: A patient is applying for a job; the prospective employer inquires about his past; the patient must decide whether or not to mention his alcoholism. Some patients objected to the way the role was played and offered to play it differently. The differences of opinion and the discussion which ensued were stimulating and led to a consensus that the man should state frankly that he had received treatment for problem drinking.

(2) To encourage community spirit, group identification and ward citizenship. Example: An aide finds a bottle of liquor which a patient, returning from leave, has tried to smuggle in; should he report the patient, with whom he is on friendly terms? In the discussion following the enactment the group approved of reporting the incident. The aides and nurses present gained reassurance that their function was understood.

Creates Fresh Reactions

(3) Affective reeducation to resolve deep-seated conflicts. Example: A passive, dependent son tells his widowed mother that he wishes to marry, set up his own home and arrange for her to live elsewhere. The possessive mother, played by a nurse, assures the son with studied martyrdom that she will manage somehow—she is too old to worry about. A situation of this type makes the patient at whom it is aimed uneasy; it is unexpected and therefore evokes spontaneous and fresh reactions, not allowing for glib intellectualization.

From the Traverse City (Michigan) State Hospital, G. S. Evseeff describes a modified psychodrama technique, employed as a device to help a patient develop insight into his own emotional problems, which otherwise he tends to project onto members of his family or other alcoholics. Two patients are selected to play extemporaneous roles in a given situation.

Promising Form Of Group Therapy

The situations chosen are based on the most common dynamic factors entering into the personality structure of alcoholics: conflict with authority, un-

resolved familial attachments and jealousies, wife as mother figure, latent homosexuality, conflict with law, failure to achieve ideas, suicidal tendencies, "girl friend" and marriage conflicts. On the basis of still limited experience Evseeff believes that this is a promising form of group therapy for alcoholics.

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AN INTERESTING STUDY—

In the May 26 issue of *The Journal of the American Medical Association,* there is a highly informative study on "Personality Structure in Relation to Antabuse Therapy of Alcoholism," by Captain Paul W. Dale, Medical Corps, United States Army and Dr. Franklin G. Ebaugh of Denver, Colorado.

The actual scientific name for Antabuse is Tetraethylthiuramdisulfide, a newly discovered drug found two years ago by the Danish physicians J. Hald, E. Jacobsen, and V. Larsen. Antabuse in some way alters the normal metabolism of ethyl alcohol, creating a biochemical intolerance to alcohol, the feature explains.

Found on page 314 of the J.A.M.A., the article describes itself as "A study of the emotional reactions of the alcoholic to (Antabuse) therapy and of those patients who have not abstained from alcohol. These aspects are related to the personality structure of the individual alcoholic patient."

According to this interesting study, it has been noticed in many patients, depending on the structure of their personality, the appearance of psychologic reactions to Antabuse therapy. And it is with the psychologic aspects of this therapy that the study deals.

In the words of the study, "We think that an analysis of the patients who have had relapses while on (Antabuse) therapy will enable us (1) to make some observation concerning the psychologic implications of (Antabuse) to the alcoholic, (2) to improve our therapeutic tools to be used concurrently with (Antabuse) therapy, (3) to make a wiser selection of patients and (4) to improve the overall approach to the problem of chronic alcoholism, with fewer patients falling into the group who have relapses."

INVENTORY heartily recommends this interesting feature to all of its medical readers.

RESPONSE AND RESPONSIBILITY

The first issue of INVENTORY in May was a new venture for the Tar Heel state. For the first time, North Carolina chose to approach society's ancient problem, alcoholism, through a program of public information based on scientific research and sympathetic realism.

Response to the state's first journal on alcohol and alcoholism has been far more encouraging than the ARP staff could possibly have anticipated. Letters and comments from many sections of the state and nation have kindled INVENTORY'S determination to remain worthy of its readers.

A major responsibility is to keep the journal objective and soundly balanced. This journal endeavors to make every article readable, understandable, and helpful to the citizens for whom it was created. Such balance and clarity demand a variety of articles on the various phases of alcohol-related problems.

Such variety often demands more space than there is in a single issue. Like other publications, INVENTORY can only "hold for the next issue" all interesting, informative features left unprinted because of space limitation. Contributed materials are welcomed, however, and equal space is available to all members on the great team of alcoholic treatment, rehabilitation, education, and prevention.

"THE MOST FREQUENT DENOMINATOR"

During a medical practice of 50 years, Dr. James T. Fisher, a veteran American psychiatrist, has learned some valuable rules for living. His recent autobiography puts activity with a purpose and love for others at the top of these rules.

At the age of 87, Dr. Fisher puts it this way in his latest book: "Of the thousands of mentally and emotionally abnormal I have observed in more than a half century, I believe that the one most frequent denominator among them has been a lack of worthy purpose in life, a lack of ambition or a lack of opportunity to be of some definite purpose in society; to make some definite and at least partially unselfish contribution to the world."

The veteran psychiatrist points vividly to the source of all rules for living as one brace against emotional instability:

"If you were to take the sum total of all the authoritative articles ever written by the most qualified of psychologists and psychiatrists on the subject of mental hygiene—if you were to combine them and refine them and cleave out the excess verbiage—if you were to take the whole of the meat and none of the parsley, and if you were to have these unadulterated bits of pure scientific knowledge concisely expressed by the most capable of living poets, you would have an awkward and incomplete summation of the Sermon on the Mount."

INVENTORY

If we are to understand the illness of alcoholism, we must take an inventory of what we know and don't know about beverage alcohol and human personality.

If we are to solve the problems of alcohol, we must identify ourselves with the illness of alcoholism. Major and *curable* maladies of today were considered incurable for years, until society chose to tackle them rather than avoid them.

Such identification takes teamwork. It takes the hospital and its physician, the church and its minister, Alcoholics Anonymous and its experience, the family and its newspaper, the public school and its teacher, the radio and its public forums, the health, welfare departments and their trained case workers.

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INVENTORY

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

Published By THE N. C. ALCOHOLIC REHABILITATION PROGRAM

Vol. I SEPTEMBER, 1951 No. 3

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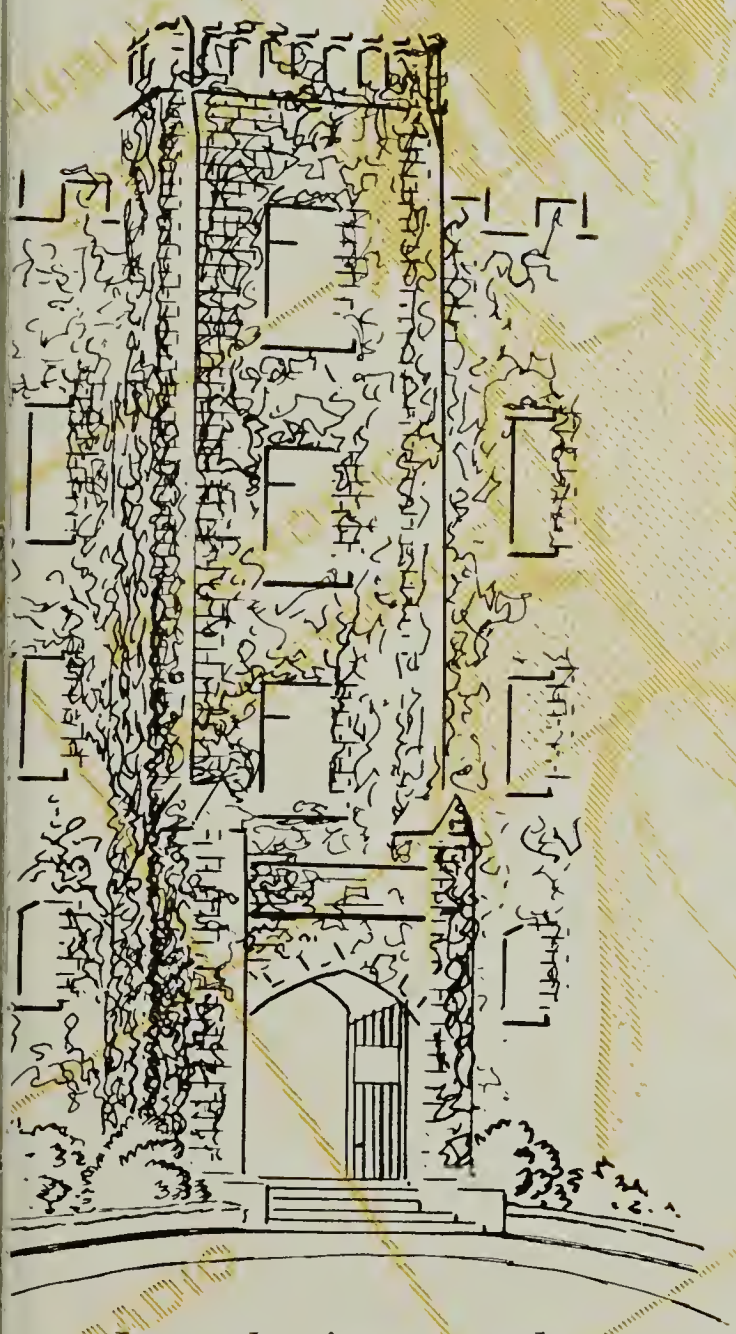

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TREATMENT REHABILITATION EDUCATION PREVENTION

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LORANT FORIZS, M. D.....*Medical Director, ARP*

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C., UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

IT CAN BE DONE

As stated in July's INVENTORY, the average North Carolina general hospital usually casts a wary eye at any proposal for the treatment of chronic alcoholism within its plant. In addition to the ruthless stigma many communities attach to the illness, there are always the practical questions of the hospital's administrator and medical staff.

Questions of discipline, costs, and reputation naturally arise. In a recent visit to the famed Alcoholic Pavilion of New York City's Knickerbocker Hospital, INVENTORY learned some interesting facts about caring for alcoholics in a general hospital. The digested impression was that a general hospital which will offer adequate treatment for chronic alcoholism eventually enhances its services and its name in the general public's eye.

Knickerbocker launched its pioneer program in 1945, admitting patients that are selected and sponsored by members of Alcoholics Anonymous. The sponsor accompanies the patient through the emergency entrance, clears all financial details, remains through examination and formal admission, and returns for the patient upon discharge.

No one is admitted unless he is an alcoholic, cannot stop drinking without help and expresses a need for that help. The usual period of hospitalization is five days. The treatment is not complicated. Proper diet, vitamin therapy, and ample sleep go far in allaying the jitters and shakes and restoring a normal appetite for nourishing food.

A private pavilion on one floor serves as the alcoholic center, with five single rooms, four 2-bed rooms, and one 6-bed room called "Duffy's Tavern" by the patients. Depending upon sex and condition, new patients occupy single or 2-bed rooms. Two and three-day men move to "Duffy's", and the women occupy their original rooms until discharged.

The staff consists of a psychiatrist, House physician, a head nurse, four general duty nurses, and two nurses aids. Assisted by AA volunteers, these employees provide sufficient care for the patients many of whom "pitch in" with the routine tasks of serving trays, etc. Knickerbocker's Director of Nursing has found the Pavilion "most satisfactory."

Two North Carolinians, prominent in Tar Heel alcoholic rehabilitation work, pause with Knickberbocker's assistant administrator and the Alcoholic Pavilion's head nurse before taking a tour of the pioneer Pavilion.

Left to right they are: David Cox, Raleigh; Chief Nurse Teddie Rohan, the nursing profession's successor to the late beloved champion of Alcoholics Anonymous, Dr. William D. Silkworth; Dr. Lorant Forizs, medical director of the Butner ARC; and Assistant Administrator L. G. Terenzio.

According to Knickerbocker Administrator L. B. Dana, "The patient is told the nature of his illness by the doctors, nurses and AA visitors. He is treated as a sick person. Harsh words and recriminations are tabu. Physical restraints are seldom necessary, although AA members give many hours as volunteer attendants.

"They understand what the patient is going through, how to quiet and reassure him. Some day an epic should be written on the unselfish service voluntarily given by these devoted men and women."

Administrator Dana gives the following conclusions from five years of experience: "The alcoholic is a sick person and, in many instances, can be helped by proper medical and psychiatric treatment.

"Generally speaking, the patients offer no disciplinary problem. It is quite feasible to care for such patients in a general hospital if they are properly screened. Such a service need not interfere with other hospital services. It posses no great nursing problem. It is less expensive to operate than a general surgical or medical service.

"It is desirable to operate a service in close cooperation with Alcoholics Anonymous. It is highly worthwhile because of the number of "sick people" restored to useful family and vocational life. The changes wrought by scientific medical care and psychological direction in such a short time are amazing."

The Little Doctor Who Loved Drunks With Fatherly Insight

A drunk is lying on a bed in a hospital, and a doctor is sitting beside the bed. The drunk is talking earnestly to the doctor.

". . . a wave of depression came over me," the drunk is saying. "I realized that I was powerless—hopeless—that I couldn't help myself, and that nobody else could help me. I was in black despair. And in the midst of this, I remembered about this God business . . . and I rose up in bed and said, 'If there be a God, let him show himself now'!"

(A doctor specializing in alcoholism hears all kinds of crazy stories from drunks in all stages of de-fogging. You'd expect him to have his tongue in his cheek at this point.)

"I Felt An Immense Joy"

"All of a sudden, there was a light," the drunk goes on, "a blinding white light that filled the whole room. A tremendous wind seemed to be blowing all around me and right through me. I felt as if I were standing on a high mountain top . . ."

(You'd think a doctor would become hardened after listening to these drunks rave day after day. It's a discouraging, thankless field . . . alcoholism.)

The drunk continued: "I felt that I stood in the presence of God. I felt an immense joy. And I was sure beyond all doubt that I was free from my obsession with alcohol. The only condition was that I share the secret of this freedom with other alcoholics and help them to recover."

"Tell Me Doctor—Am I Insane?"

The drunk paused and turned to the doctor. "Ever since it happened, I've been lying here wondering whether or not I've lost my mind. Tell me doctor —am I insane—or not?"

The drunk was Bill W.

Fortunately for Bill—fortunately for AA—fortunately for the thousands of us who have come after—the doctor was Dr. Silkworth. By great good luck—or by the grace of God (depending on your viewpoint)—the doctor was Dr. Silkworth.

It would have been so easy to dismiss Bill's experience as hallucination, one of the many possible vagaries of a rum-soaked brain. And a disparaging word from the doctor right at this point could have choked off the tender shoot of faith and killed it.

Alcoholics Anonymous might have got started somewhere else, somehow. *Or it might not.* Certainly it wouldn't have started here. Very possibly the life of every one of us AAs hung on the doctor's answer to the question, "Am I insane?"

It was here that Dr. Silkworth made the first of his indispensible contributions to AA. He knew—by an insight that no amount of medical training alone can give a man—that what had happened to Bill was real, and important.

"I don't know what you've got," he told Bill, "but whatever it is, hang on to it. *You are not insane.* And you may have the answer to your problem." The encouragement of the man of science, as much as the spiritual experience itself, started AA on its way.

When Dr. Silkworth died of a heart attack in his home in New York early in the morning of March 22nd, even those AAs who knew him best and loved him most awoke to the realization that we had lost a great friend, a greater doctor, a greater man than we had ever realized.

A Prodigious, Relentless Worker

It was particularly hard to appreciate the greatness of the man while Dr. Silkworth was yet with us, because of his profound personal modesty and the disarming gentleness, the unassuming and almost invisible skill, with which he accomplished his daily miracles of medical and spiritual healing.

We knew that he was a prodigious and relentless worker, but still it was a shock to discover that in his lifetime of work with those who suffer our disease, he had talked with 51,000 alcoholics—45,000 at Towns Hospital and 6,000 at Knickerbocker.

Yet he was never in a hurry. And he had no "formulas," no stock answers. Somehow he found out very early that the unexpected was to be expected in alcoholism, and for a man who knew as many of the answers as he did, he came to each new case with a wonderfully open mind . . . the great and classic example of which is his handling of Bill.

And this gentle little doctor, with his white hair, and his china blue eyes—child's eyes, saint's eyes—was a man of immense personal courage. It must be remembered that he went much farther than merely encouraging Bill's faith in his spiritual experience.

A Highly Unorthodox Undertaking

He saw to it that Bill was permitted to come back into Towns Hospital to share his discovery with other alcoholics. Today—when "carrying the message to others" has become a very respectable part of an undeniably effective program—it is easy to forget that "carrying the message" in the beginning was a highly unorthodox undertaking. It had no precedent and no history of success; most authorities would have turned thumbs down on it as just plain screwball.

Again, we forget how our technique has been mellowed and refined by the wisdom of experience. We know now that the blinding light and the overwhelming rush of God-consciousness are not necessary, that they are indeed very rare phenomena and that the great majority of recoveries among us are of the much less educational kind. But in the beginning the "hot flash" was stressed—nay, insisted upon.

Dr. Silkworth had his professional reputation to lose, and nothing whatsoever to gain, by permitting and encouraging this unheard-of procedure of one God-bitten drunk trying to pass on his strange story of a light and a vision to other alcoholics—most of whom at that time received it with lively hostility or magnificent indifference.

Then Bill met Dr. Bob, and the first few drunks, incredulously, began to

make their incredible recoveries. The infant society, without a book, without a program really, and without reputation or standing of any kind—began its growth. We forget how halting and feeble that early growth was, how bedevilled with obstacles in a world skeptical of spiritual experience and often hostile to it.

Dr. Silkworth from the beginning threw all of his weight as a doctor, a neurologist, a specialist in alcoholism, into aiding the progress of this mongrel and highly unpedigreed society in every possible way.

He committed social and professional heresy right and left in order to publish and implement his burning faith in a movement which as yet only half-suspected its own destiny and which had to grope rather blindly to find terms for its own faith in itself.

When there was need for money to publish the book "Alcoholics Anonymous", Dr. Silkworth used his personal influence without stint to help raise the money.

As a preface to the book he wrote the chapter titled, "The Doctor's

With the consent of L. B. Dana, administrator of Knickerbocker Hospital, and the patients, INVENTORY took this picture of some North Carolinians visiting "Duffy's Tavern," largest ward and assembly room on Knickerbocker's famed Alcoholic Pavilion.

Attending Yale's Summer School of Alcohol Studies, the students took a day's tour of Knickerbocker and other pioneer A. A. facilities in New York City. Talking with the patients are Tar Heels Charles Auman, Bob Denny, Dave Cox and Dick Moester.

Opinion," giving AA his praise and approval without reservation or qualification—at a time when there were only a thin one hundred of us dried up!

He was indeed our first friend, and indeed a friend in need. His faith in us was firmer than our faith in ourselves. Bill says: "Without Silky's help, we never would have got going—or kept going!" Again his contribution was indespensible.

Why did he do it?

The answer to that is the answer to Dr. Silkworth's whole career: he loved drunks. Why he loved drunks is a secret known only to God and the doctor—and perhaps the doctor himself did not wholly understand the mystery. "It's a gift," he used to say, his eyes twinkling.

He discovered his gift very early in his medical practice. He was graduated from Princeton in 1896, and took his medical degree at New York University in 1900. Then he interned at Bellevue; and it was while working at Bellevue that he found he was drawn to alcoholics, and they to him.

Some Kind Of Thawing Influence

When nobody else could calm a disturbed drunk, Dr. Silkworth could. And he found, rather to his amazement, that even the toughest and most case-hardened of drunks would talk to him freely—and that many of them, even more amazingly, wept. It became evident that he exerted—or that there was exerted through him—some kind of thawing influence on the frozen life-springs of the alcoholic.

Yet the years that followed were full of discouragement. There were two years on the psychiatric staff at the U. S. Army Hospital at Plattsburg, N. Y., during the first world war, followed by several years on the staff of the Neurological Institute of the Presbyterian Hospital in New York.

Twice he entered into private practice, only to be drawn back into hospital work with alcoholics. His work continued on at Charles B. Towns Hospital, New York, a private hospital specializing in alcoholism and drug addiction. Here, Dr. Silkworth's special skill with alcoholics—and his growing understanding and love for them—had full scope.

Often Profoundly Discouraged

Yet he estimated that the percentage of real recoveries among the alcoholics he worked with was only about 2 per cent. The large number of hopeless cases, and the deep degrees of human tragedy and suffering involved, weighed heavily upon the gentle doctor. He was often profoundly discouraged.

Then came Bill—and AA.

One who has known the doctor intimately over many years has said this about it: "Silky never told me this: It's my own opinion. But I believe that AA was Silky's reward. All those years he plodded along—treating drunks medically—defending them—loving them—and not getting anywhere much. And then God said: 'All right, little man, I'm going to give you and your drunks a lift!' And when the lightning struck, there was Silky, right where he belonged—in the midst of it!"

Early in his career, at a time when alcoholism was almost universally regarded as a willful and deliberate persistence in a nasty vice, Dr. Silkworth

came to believe in the essential goodness of the alcoholic. "These people do not want to do the things they do," he insisted. "They drink compulsively, against their will."

One of the early drunks who Dr. Silkworth treated, a big husky six-footer, dropped on his knees before the doctor, tears streaming down his face, begging for a drink. "I said to myself then and there," Dr. Silkworth related, "—this is not just a vice or a habit. This is compulsion, this is pathological craving, this is a *disease!*"

He loved drunks—but there was nothing in the least degree fatuous or sentimental about that love. It could be an astringent love, an almost surgical love. There was the warmest of light in those blue eyes, but still they could burn right through to the bitter core of any lie, any sham. He could see clean through egotism, bombast, self-pity and similar miserable rags that we drunks use so cleverly to hide our central fear and shame.

He Had A Gift—Which He Shared

All this he did—without hurting anyone. While insisting rigorously that recovery was possible only on a moral basis—"You cannot go two ways on a one-way street"—he never preached, never denounced, never even really criticized.

He brought you, *somehow,* to make your own judgments of yourself, the only kind of judgments that count with an alcoholic. How did he do it? "It's a gift." Just coming into his presence was like walking into light. He not only *had* vision—he *gave* vision.

There is not room here—nor has there been opportunity for the necessary research—to consider his status as a medical man. It can be said that he held a position of very high eminence in his profession. He encountered opposition to some of his views, and he was latterly the recipient of very wide-spread recognition and praise for his work.

It is literally true that he was the world's greatest practical authority on alcoholism. His pioneering work in the concept of alcoholism as a manifestation of allergy has been validated by later experience and has been the subject of a great deal of medical interest and research just recently.

A Father To The Knickerbocker Center

Dr. Silkworth's was a great contribution to the establishment and development of the alcoholic treatment center at Knickerbocker Hospital in New York. In later years, he was sought out for consultation and advice by doctors and by those in charge of state and city alcoholic treatment projects.

There was a steady stream of visitors, some of them from foreign lands. Also, every day, there were long distance telephone calls from those seeking further help, those seeking his advice—all over the U. S.

There remain these things to be noted: Dr. Silkworth was a small man, well under medium height. His complexion was ruddy. His remarkable eyes have been mentioned. His hair was snow white—and no member of AA knew him otherwise, for he was already well along in years when our relationship began.

You would say that the habitual expression of his face was a smile—until

you thought about it, and realized that the features were really nearly always in repose, and the impression of a smile arose actually from a certain light about his face. (Too many of us have noticed it to be mistaken!)

He loved to be well-dressed—was, in fact, quite dapper—and in this he was not without a certain whimsical and self-recognized vanity. Nurses—the hospital staff—everyone who worked with him quite plainly and simply adored him. He was unfailingly gentle, courteous, thoughtful. He was happily married, and he and Mrs. Silkworth shared a delight in growing things—in flowers—in gardening.

A Saintly Man Who Saved Many Lives

He was utterly and completely indifferent to money, to position, to personal gain or prestige of any kind.

He was a saintly man.

We drunks can thank Almighty God that such a man was designated by the divine Providence to inspire and guide us, individually and as a group, on the long way back to sanity.

And now—in this anonymously written journal of an anonymous society—I hope I may be permitted, in closing, the anomaly of a personal note. You see, Dr. Silkworth saved my life. I was one of those "hopeless" ones

In the courtyard of an uptown New York A.A. group, North Carolina Yale students Dave Cox, Dorothy Ennis, and Mary Ruth Davis listen to a local citizen explain the services of the group's meeting quarters and lunch room which is kept open daily.

According to those who know, "Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism."

whom he reached and brought back to life—to AA—and to God. And I have wanted very much to write this tribute faithfully and well, in the name of all those who share my debt and gratitude.

And yet I have realized from the beginning that this article will entirely please nobody. To those who knew and loved the saintly doctor, it will seem insufficient. And some of those who didn't know him may think it overdone, for the truth about Dr. Silkworth is strong medicine in a materialistic age.

This dilemma would be tolerable, were it not for a third difficulty: I have written all along in the uneasy knowledge that what is said here is by no means pleasing to the doctor himself.

The incident of physical death certainly has not placed him beyond knowledge of what goes on here below. And he will not be pleased with all this, because while he was stern about very few things, he was sternly and seriously opposed to the publication of his own name and fame.

I take comfort, however, in the fact that his sense of humor most certainly will have survived his recent transition to a New Home. And I feel sure that his disapproval of the present essay will be tempered by amusement, and by the priceless gift he gave us all so freely while he was yet as we are—his great love.

From the A. A. "Grapevine," international journal of Alcoholics Anonymous, by special permission of the editor.

Results Speak For Themselves

A booklet published sometime ago by the A.A. *Grapevine* contained a list of highly interesting highlights in the history of Alcoholics Anonymous. As a sincere admirer of this fellowship, INVENTORY takes the liberty here of printing these highlights as they appeared in the special booklet.

Bill's first day of sobriety: December 11, 1934
Bill met Dr. Bob: Mother's Day, 1935, Akron, Ohio
Dr. Bob's first day of sobriety: June 10, 1935
First A.A. group: Akron, Ohio, 1936
First plans for A.A. movement began Fall, 1937
Twelve Steps written: 182 Clinton St. Brooklyn, N. Y. 1938
Book, *Alcoholics Anonymous* published: April, 1939
Rockefeller Dinner: Union Club, NYC, February 18, 1940
First "by male only" group: Little Rock, Arkansas, 1940
First A.A. clubhouse: New York City, June 18, 1950
First Foreign A.A. Group: Australia, 1942
First issue of *The A.A. Grapevine*: June, 1944
First Hospital Plan: Knickerbocker Hospital, NYC, April, 1945
First draft of 12 Traditions of A.A.: Published Grapevine, April, 1946
First draft of Short Form Traditions: Published Grapevine, November, 1949
First International Conference: July, 1950

The booklet also presented the following figures on the impressive growth of Alcoholics Anonymous after its first years of feeble existence. First year, 3 members; second year, 15 members; third year, 40 members; fourth year, 100 members; Spring 1950, 96,475 members. By the summer of 1951, the total had climbed to 120,000 around the globe. As one psychiatrist said to INVENTORY, "The results speak for themselves"

World Health Experts Outline Program To Combat Alcoholism

Prevention and treatment of alcoholism as a medical and social problem should become a regular function of public-health administrations, according to a group of experts on alcoholism which met recently under the auspices of the World Health Organization in Geneva.

The group, which is a sub-committee of the WHO Expert Panel on Mental Health, outlined a pioneer program to treat alcoholism on medical and scientific lines and pointed out that this new outlook was different from the approach of lay reform groups, and should not be confused with political and social action against alcohol.

Committee Defines Alcoholism

The Committee's first recommendation was that the World Health Organization should take all steps within its power to stimulate public health services to act to prevent and treat alcoholism. To do so they should provide treatment facilities and advisory, educational and other services on this subject.

The lack of a commonly accepted terminology on alcoholism was recognized by the experts as a serious obstacle to international action in this field. In an effort to clarify this situation, the Committee proposed to define alcoholism as "any form of drinking which in its extent goes beyond the traditional and customary dietary use, or the ordinary compliance with the social drinking customs of the whole community concerned . . ."

Three Steps Toward Alcoholism

From a clinical point of view, the Committee agreed that the development of alcoholism passes through a series of recognizable stages, each of which has a different significance both for prognosis and treatment. The three stages are "symptomatic drinking," "addictive drinking," and appearance of organic damage or psychic deterioration.

In the first stage of "symptomatic drinking," alcohol is taken to deal with a current problem, e.g. stress on the individual arising either from physical conditions, (for instance, to overcome tiredness, pain or insomnia), from psychological conditions (anxiety and in-

feriority feelings), from social circumstances (family or job difficulties) or from a combination of all these factors.

Second Stage Of Addictive Drinking

In such cases, the current stress is temporarily relieved by drinking, but a vicious circle may be created and the second stage of "addictive drinking" may be reached, where the patient drinks to mitigate the symptoms provoked by previous excessive drinking.

Such symptoms may be physical, as gastritis, lack of appetite, and psychological or social, as may be feelings of inferiority arising from behavior while intoxicated, disturbances of personal relationships, or occupational ineffectiveness. Alcohol is then used to blunt the additional problems resulting from previous drinking.

As regards the "addictive" characteristics of alcohol, the experts urged that the WHO Expert Committee on Drugs Liable to Produce Addiction consider this and other matters concerning alcohol referred to in its report.

Organic Damage, Psychic Deterioration

The third stage in the development of alcoholism, they went on to say, is the appearance of organic damage or psychic deterioration (polyneuritis, cirrhosis of the liver, Kosakoff psychosis, etc.) Appearance of organic damage depends on factors additional to the extent and length of excessive drinking, and grave diseases are particularly apt to occur in countries where nutritional deficiencies are common and where the medical treatment of acute intoxication is inadequate.

As regards treatment of alcoholism, the experts felt that at the stage of "symptomatic drinking," it was in many cases possible to deal with the underlying cause and that after success had been achieved, the patient could resume moderate drinking. In the second or addictive stage, the aim of therapy should be complete abstinence, as it is in the third stage.

Drinking Customs Vary By Nations

Analyzing the extent and nature of the problem of alcoholism, from an international point of view, the Committee stated that there is extreme variation in social drinking customs in different countries, in the types of beverages consumed and in the average level of consumption in different populations.

In some countries, urban life is associated with a higher rate of

alcoholism, while in others the higher rate is to be found in rural communities. High alcoholic consumption may in one place be characteristic of upper-level socio-economic groups, while in another it is at its highest at the lower end of the scale.

Development Of National Statistics

Similarly, the level of per capita alcoholic consumption in a country is no concrete evidence of the incidence of alcoholism in that country. For instance, reduced production and consumption of alcoholic beverages in France during the war resulted in a decrease of alcoholic cases with organic complications, while in Denmark it was not certain that the same factors had produced a similar decrease.

In order to clarify the problem the Committee urged the development of national statistics within every country on the incidence of alcoholism. According to a formula developed by Dr. E. M. Jellinek, of Yale University, an approximation of the number of chronic alcoholics can be roughly determined for a number of countries, and has been confirmed from various sources.

Breakdowns By Nations

Thus in Switzerland on the basis of this formula the number of alcoholics presenting complications is estimated at approximately 50,000, in Chile 43,000, in France 375,000, in Yugoslavia 90,000, in the U. S. A. 945,000, in Australia 34,300, in Sweden 30,800, in Italy 135,800, in Norway 8,400, in Finland, 8,800, in England and Wales 86,000, etc.

The numerical importance of such groups emphasized the need for adequate treatment facilities, according to the WHO experts. The Committee felt that all efforts should be made to bring to light early cases of alcoholism where treatment is at its most valuable and successful, and was of the firm opinion that out-patients dispensary services are necessary.

Value Of General Hospital Facilities

Such services can in the early stages of the disorder produce a high proportion of successful results, and are best situated in well-equipped general hospitals, at very small cost.

The Committee believed that if adequate networks of dispensary services at general hospitals were developed, the need for special residential institutions for alcoholics would progressively diminish.

MEDICAL APPROACH ADVOCATED

As regards means of treatment, the WHO experts felt that a medical approach devoid of any implications of moral censure, and backed by psychotherapy and social work would offer the best results. Important new drugs such as tetraethylthiuramdisulphide (Antabuse), when used by qualified physicians, are a valuable aid in well-chosen cases.

Drugs—As Aids To Treatment

A strong warning against their use without specialist medical supervision was issued by the WHO experts who pointed to several fatal cases. Where this does not prove of value the Committee recommended the "aversion" therapy based on the use of apomorphine or emetine but pointed out that no existing drug is a cure for alcoholism. They are rather aids to treatment.

Recent advances in endocrinology offer additional aids to the handling of acute clinical problems of alcoholism; ACTH and Cortisone were reported to be of considerable value in the handling of delirium tremens, acute alcoholic intoxication and even Korsakoff psychosis. The Committee asked for further reports on this subject.

Deserving Praise For Alcoholics Anonymous

While recommending the establishment of training courses for medical personnel to help in prevention and treatment of alcoholism, the Committee paid tribute to voluntary organizations of the type known in the U.S.A. as Alcoholics Anonymous, an organization whose membership is composed entirely of alcoholics who have been able to become or are attempting to become abstinent.

Experience of this movement is restricted to comparatively few countries outside the U.S.A., but it is considered by many physicians to be the most hopeful social development which has taken place in the handling of alcoholism.

> Often an alcoholic will reject premature persuasion and will adopt a hostile attitude toward those who might help him, which he then feels obliged to maintain for the rest of his life.
>
> To the family of a man or woman who has been drinking to excess for many years, "premature" may seem an unfortunate choice of words. But difficult as it may be to pull punches, your tact and forebearance may save his life.
>
> You should simply inform him that professional help is available, and then leave him alone to seek it on his own initiative.—James L. Free, Consultant on Alcohol Problems, Santa Barbara (California) Mental Hygiene Clinic.

SAFE SEDATION FOR ALCOHOLICS

One of the problems which confronts the physician in the treatment of alcoholic patients is that of safe and effective sedation during the hang-over period. Paraldehyde and barbiturates have been commonly prescribed in this condition. Many physicians, however—for example, Z. M. Nason—regard it as extremely undesirable to administer to alcohol addicts drugs which can lead to the development of a new addiction, and both paraldehyde and barbiturates are regarded as highly addictive for susceptible individuals.

Recently anothed drug has been proposed for sedation of the alcoholic in the hang-over state and in a limited number of clinical trials has given satisfactory results. The drug, 3-orthotoloxy-1,2-propanediol (proprietary names: Myanesin, Tolserol), had been employed originally as a muscle-relaxing agent, to alleviate spasticity and rigidity.

To Patients In Anxiety States

L. S. Schlan and K. R. Unna, at the Manteno State Hospital (Illinois), administered it to patients manifesting anxiety states, in several types of psychosis, and in alcoholism. Their report of its effects in 63 patients includes eight alcoholics all of whom were in a state of hang-over, following prolonged bouts, and exhibiting the clinical picture frequently described as "the shakes."

The drug was given in doses of 0.5 to 1.5 grams four times a day, either in tablets (0.25 gram) or in syrup of eriodictyon and propylene glycol (1 gram per 30 cc.). The signs of severe anxiety, as well as gross tremor, were noticeably relieved 30 to 60 minutes after ingestion of the drug. The patients reported that they felt comfortable. They were able to lift a cup of coffee to the lips with one hand without spilling, whereas before the medication they had been unable to do this with both hands.

The patients, all of whom had been previously admitted on numerous occasions and had formerly received paraldehyde or barbiturates, stated that the relief experienced from the new drug was more prompt than from either of the other sedatives. They felt also that it left them more "wide awake" and closer to "normal."

Relief For Hang-over Symptoms

3-Ortho-toloxy-1,2-propanediol is a depressant of the central nervous system which acts on intercommunicative neurones. C. C. Pfeiffer and K. Unna, in reviewing the application of various drugs in the treatment of alcoholic patients, discuss the action of this drug. They believe that its beneficial effect in hang-over is due to an interruption or depression of reverberating closed circuits of excitement in the system of nervous intercommunication.

They emphasize the fact that this drug is not applicable to the treatment of alcohol addiction itself. It does not stop the craving for alcohol, nor does it create an aversion to it. Its only use in alcoholism is for the relief of some of the symptoms of hang-over, such as tremor, and for the alleviation of anxiety without clouding of consciousness.

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---To Know And To

"Come in, Ted. It's good to see you. What's up?"

"I don't know how to explain it, Bob, but I know it's got to come out of me sometime soon."

"What's got to come out, Bob?"

"Don't you fellows have a code, or something—some steps about admitting your problems to God, as you understand Him, to yourself, then to one other human being?"

"That's one of the steps, Ted. There are twelve of them actually, but it's hard to put one above the other. Together they form a kind of stairway. Why do you ask? Do you believe you have a problem?"

"Yes, I feel pretty sure I do, but I, I—"

"You know, Ted, you've got to be really sure about something like this. And only you can tell or can feel the certainty of it."

"Yes, I have a problem, Bob. I guess you'd call it alcohol. But somehow I don't think alcohol's the major factor in my case."

"It probably isn't, Ted. It might go deeper than that. It did with me. It does with most of us. If we didn't use alcohol to avoid that 'deeper factor', we'd use something else."

"I attended one of your Alcoholics Anonymous meetings the other night, Bob—on the back row, out of curiosity more than anything else. At least, I thought it was out of curiosity. But I learned something important for me. You people call it 'high bottom' and 'low bottom.' You say that all men with alcohol problems don't have to hit 'skid row' before realizing their condition and their need. The speaker spoke at length on the 'high bottom,' the fellow who's fortunate enough to realize his plight before he loses everything."

"That's right, Ted. More and more men every day are realizing their 'tendencies', you might say, before hitting 'low bottom'."

"I hate to admit it, Bob, but I believe I have some of those tendencies you speak of, at least, I know I feel uneasy in a way I can't understand or can't describe."

"You're lucky, Ted, very lucky to have this feeling at this time—before going through the awful experiences many of us fellows have endured."

"What do you mean lucky, Bob? There's such a stigma to it, so much neighborhood scorn over being recognized as an alcoholic—especially when you come out and admit it."

"What difference do people make, Ted, when you are searching for an answer to the uneasiness and the fears you say you can't understand or describe?"

"I guess I fear the ridicule and scorn, or the gossip or something. Don't you?"

"Once I did, but no longer. Ted, have you ever seen or read our Twelve

Accept The Difference

Steps? You know, we aren't crusaders. We're average human beings who admitted we were powerless over alcohol, who turned to God, and are now available to any man or woman who wants help in overcoming alcoholism. The degree of addiction doesn't matter to us. The desire for help is all that matters. If you desire that help, I'll be glad to offer some suggestions."

"I desire help, Bob, with all my heart I desire it."

"First, let me say this, Ted. I know what you mean when you say you are uneasy and confused. I know because I have been there. Don't think you have to have a string of commitments and so forth to be sick in your soul and mind. You're probably right—alcohol is probably a minor symptom in your case."

"What would you say is my problem, Bob, something concrete I can put my hands on?"

"Well, I'm no doctor or minister. I'm just a salesman and a recovered alcoholic, though we always like to think of our condition as being arrested like tuberculosis. If you can tell me your story from the beginning, I'll tell you where our cases are similar and what I did and what I found."

"It's not so spectacular, Bob, like some I heard at the open A. A. meeting the other night. It's been a kind of creeping thing with me, but when I entered the Army some eight years ago . . ."

Into and beyond the midnight hour, the confused man named Ted related his story to the understanding man named Bob, and there appeared experiences both typical and unique—black-outs, sneak drinks, solitary drinking, remorse and guilt, indefinable fears, but no benders, no geographic escape, no eye-openers—both typical and unique.

Throughout the personal revelations, Bob inserted practical advice based on personal experiences similar to the situation being related at the moment. When Ted finished, there was silence, there seemed little left for Bob to say or advise, until he pulled a neatly printed card from his pocket and handed it to Ted.

Smiling hopefully, he suggested, "If you can use this, Ted, take it and keep it with you for a while, and maybe it'll help level out some of the rough spots."

The two men shook hands firmly in the door of Bob's apartment, and the faithful member of Alcoholics Anonymous concluded, "Take it easy, Ted, and come to see us often, you're always welcome."

At the edge of the steps, Ted stopped and held the card under a hall light at a reading angle, and his lips moved slowly across the word "THINK" in bold letters at the top of the card. Below the key word, there was a three-line sentence at which Ted stared until he was squinting through salty liquid:

"God, grant me the serenity to accept things I cannot change, courage to change things I can, and wisdom to know the difference."

INTO THE HALLOWED HALLS THEY WENT
REALISM, OF THINGS EQUAL AND UNEQ

For a full month of lectures and seminars, of morning, afternoon, and evening hours spent in the study of alcohol and all its related problems, these North Carolina citizens attended the 1951 Yale University Summer School of Alcohol Studies. For their efforts, they received a certification of successful completion of "The Summer Course in Alcohol Studies at Yale University." Along with Tar Heel graduates of the past eight years, they will be invited from time to time to visit the ARP's Center at Butner, to receive the latest suggestions for carrying scientific, unbiased facts on alcoholism to their respective communities.

Five prominent members of the Yale staff stand in front: Dr. Selden Bacon, Director of the School; Dr. E. M. Jellinek, a founder of the Course and world authority on alcoholic problems; Dr. Robert Straus, staff sociologist; and Ralph M. Henderson, popular Field Representative for the School.

On the first row, left to right, are: Miss Jinsie Underwood, teacher, Gastonia; Mrs. Louise Cornett, registered nurse, Newland; Miss Jane Latham, caseworker, Charlotte; Mrs. Amalee Ritchie, teacher, Landis;

INTO THE IVY PORTALS OF THEORY AND L, INTO THE LAND OF MEETING MINDS

Miss Mary Ruth Davis, public health nurse, Robbins; Mrs. Margaret Strickland, teacher, Kinston; Miss Dorothy Ennis, teacher, Greensboro; Miss Lillian Hunt, Y.W.C.A. director, Durham.

Second row: John Nicholson, teacher, Salisbury; Charles Auman, psychiatric social worker, Butner State Hospital; Judson Dicks, classroom supervisor, Fort Bragg; David Cox, advertising salesman, Raleigh; Rev. Harold Roland, minister, Durham; Robert Denny, senior vocational counselor, Salisbury; Rev. Moses Delaney, professor, Shaw University, Raleigh.

Third row: Bruce Hunter, teacher, Asheville; S. W. Martin, educational director, ARP, Raleigh; Rev. Harry Hubbard, chaplain, Oteen V.A. Hospital; Rev. W. R. Grigg, minister, Winston-Salem; Rev. Harold Hayward, minister, Matthews; Rev. Maynard Fountain, minister, Asheville; Peter Cooper, director, Department of Education, Rowan County A.B.C. Board, Salisbury; Rev. James Fowler, minister, Forest City.

Not present for the picture were Dr. Lorant Forizs, ARP medical director; Joseph Bogle, Asheville; Dick Moester, Winston-Salem.

IT DOESN'T "JUST HAPPEN"

A new and highly interesting attitude toward alcohol seems to be arising within society. Its basic concept is that most alcohol-related problems can be solved by the personal responsibility each citizen learns to take toward alcohol.

Such responsibility doesn't "just happen." It is born of honest education based on fearless scientific truth. Such education also doesn't "just happen." It requires a penetrating analysis and presentation of three major areas: The make-up of alcohol itself, the effect of alcohol upon the human body, and the relationship of beverage alcohol and human personality.

The ingredients of alcohol itself are well known, universally accepted facts. The effects of alcohol upon the human body have been studied, are currently being studied for new discoveries that supplement and in some case repudiate fragmentary findings of the past. Examples illustrate this point.

For years, popular conception called alcohol a stimulant, a "pick-me-up" —when actually it is a depressant, an anesthesia, a sedative.

On the other hand, popular conception once said alcoholism is inherited through a "family weakness for it"—when actually the illness itself is acquired, not inherited, though certain tendencies might make one more susceptible to addiction in any field.

On the other hand, some people have called alcohol a "killer" of brain cells —when actually the human body rebels before it takes enough concentration of alcohol to damage tissues or organs.

Discoveries Through Education And Research

One-half of one per cent concentration of alcohol is the human blood stream's capacity before coma and possible death, Yale University's Center of Alcohol Studies reports, and nothing less than 5% alcohol concentration can irritate or injure healthy tissues or organs.

Diet neglect, vitamin, mineral, nutritional deficiences usually accompany excessive habitual drinking. Such deficiencies are the direct cause of certain tissue and organic deteriorations once blamed on alcohol alone, research authorities now report.

This picture of discoveries is not drawn to arouse political, social, or religious issues. It is drawn to illustrate the need for further research and more complete education on alcohol. How can intelligent responsibility toward alcohol be built or expected without such research and education.

The third area, and newest one in alcohol education concerns the relationship between beverage alcohol and human personality. To understand the "personality" approach to alcohol and alcoholism, we must consider three major factors that determine the status of any person using beverage alcohol: Why does he drink? How much does he drink? How often does he drink?

These elements of motive, quantity, and frequency are fundamental in determining and analyzing the sufferer of alcoholism. Does the sufferer feel inadequate, inferior, insecure? Does he let immature urges, unsatisfied needs, impossible goals, jealousies and resentments overcome him?

In this new field of alcohol and personality education, answers to questions like these are being sought. Honest research by all interested members of society is growing, especially by the physician, the minister, Alcoholics Anonymous, the trained case worker, the law officer and the teacher.

REAL PUBLIC OPPORTUNITY

For the past year, North Carolina's people have shown an increasing awareness of and a growing response to the activities of the North Carolina Alcoholic Rehabilitation Program.

Ten years ago support for such a Program would have been feeble at the best, not because the people are reactionary but because we are naturally hesitant about something we don't understand.

Today we are experiencing the progress that can be made toward any major problem when an understanding of its nature and its magnitude is brought to our people.

As we are equipped with the weapons for dealing with alcoholism, we turn understanding into victorious treatment, rehabilitation, education, and prevention.. As Governor Scott pointed out in the first issue of INVENTORY, we are using a new approach to an old problem.

We are turning from the ancient, rather abortive measures of punishment, emotion, and exhortation to the more realistic conception of alcoholism as a public health problem. When alcoholism becomes a health problem, it automatically becames a public responsibilty.

In North Carolina, the framework for this responsibility is, of course, the ARP under the State Hospitals Board of Control, its executive director and staff, the rehabilitation Center at Butner, and other Program facilities now being created.

Effective, Local Citizens Committees

This is only the framework. If we are to develop a dynamic Program, we must insure public understanding of its policies and participation in its growth. Desiring to share voluntarily in our over-all Program, many of our people want to know the area in which the private citizen can be most effective and helpful.

According to Yvelin Gardner, associate director of the National Committee on Alcoholism, "Experience has shown that civic-minded individuals can do the best job by aiding the educational phase of a State Program through concentrated action in their own local areas."

The public-action formula used in fighting cancer and tuberculosis is highly applicable to alcoholism. Local committees can be established, doctors, clergymen, editors, social workers, judges, recovered alcoholics and others, to sponsor basic, unbiased ARP data on alcoholism.

The local citizens committee can be constantly informed about the progress, aims and objectives of the State Program. In turn, the committee can help make available local resources for the rehabilitation of alcoholics through the State Program. It can help open hospital beds for acute cases of alcoholism in need of immediate attention.

It can provide speakers for local clubs, medical societies, ministerial associations, P. T. A's, etc. It can help the State staff with proposed Institutes and Symposiums for better public understanding of alcoholism, and it can sponsor radio recordings distributed by the ARP.

North Carolina's individual citizen can do much in support of the state's efforts to treat and rehabilitate today's problem drinkers and to educate and prevent tomorrow's addictive personalities.

A VIVID SOCIAL PORTRAIT

Woman Sufferer Pleads Case Of Victims Jailed For Alcoholism

On the editorial page of the Kansas City Star, there once appeared an article written by Dr. Glen Shepherd, on alcoholism. He states that alcoholism is a disease and not a result of willful turpitude. He names, as one of the frequent predisposing factors, resulting in this disease, the inferiority complex.

The Realization Of One Who Knows

No one can realize the truth of Dr. Shepherd's article as one who is afflicted with this disease.

I cannot believe that our officials of law enforcement can hold to the antiquated illusion that putting alcoholics in jail is beneficial to the alcoholic or to society; except in the most trivial and temporary way. I believe every intelligent judge must at least suspect that the damage done by this procedure far outweight its trivial and temporary benefit.

Therefore, I am not writing this with any vain hope of changing the laws or the municipal courts, nor of abolishing the mal-treatment of alcoholics practiced by the courts and by police officers.

Pleading The Case Of The Alcoholic

I am attempting only to plead the case of the alcoholic; to paint a clearer picture of this problem, perhaps, than can ever be perceived from the judge's side of the bench. And if this clearer picture should influence the sympathies of just one judge, in just one alcoholic case, I shall feel that my efforts have been worthwhile.

If poliomyelites, which is inflamation of the gray matter of the spinal cord, were the result of a shy, frustrated nature and a painful inferiority complex, it would be just as logical to put these victims through the tortures of the seventh and eighth floors of the Kansas City Jail, and then send them to Leeds, for thirty days, or six months, as it is to give this punishment to the alcoholic.

Bitter Fruit And Damp Shadows

To send a neurotic and super-sensitive personality of this type to jail has grave and serious consequences. The bewildered alcoholic doesn't know what he is being punished for, because usually he knows

that he was absolutely powerless to resist that compulsion to drink; and he doesn't feel guilty because it is neither a sin nor a crime to take a few drinks and he had not intended to take more. He does not know why he found it impossible to stop at one or two.

When the alcoholic is brought before the court, he has been suffering the most intensely acute mental and physical anguish. He has lain upon a cold iron slab in the jail for interminable hours, ill, half starved, shaking with nervousness, appalled at his plight, and in a frenzy of fear and dread for the ordeal before him. Perhaps he has been brutually kicked and beaten by the police. (I have had six bones fractured, besides numerous minor injuries inflicted by police officers.)

Natural Birth Of Anti-Social Tendencies

He is herded, pushed, insulted, and packed with the other unfortunates, into the small, airless room behind the court to await trial. He is not permitted a razor, soap or comb; and if he didn't have an inferiority complex before he became an alcoholic, he would have a fully developed one now. If he has never had any anti-social tendencies, he begins to develop them when he sees some other alcoholic get a dollar fine, while he gets sixty days.

His guilt and his penalty have not been determined because he was sixty times more drunken than the other man, nor because it was his sixtieth arrest to the other man's first. (The first time I went before the court, I received a one hundred dollar fine.) But to teach him a lesson? Had the other man learned this lesson?

Obviously, the lesson is to learn not to take the first drink. How can one learn it at Leeds?

No Sympathy, Justice, Nor Understanding

His feelings of inferiority, indecision, frustration, timidity, inadequacy, nervousness, and despair, all work together to stimulate that compelling desire for escape; and at Leeds these feelings are accentuated and brought into sharp focus, because now the alcoholic not only wants to escape from the batwinged creatures of his own brain, (his troubles, real or fancied) but he wants to escape from Leeds.

He wants, more than ever to escape from a reality in which he can find no sympathy, justice, nor understanding. He is now a jailbird; and he can think of no relief for his shame except the poisonous anodyne found in a bottle.

IT WILL WALK BESIDE HIM . . .

A Skeleton No Closet Can Hold

Previous to his first arrest, his alcoholism was the worst skeleton in his closet. His police record will become a skeleton which no closet can hold. It will walk beside him intimidating and under-mining his self-confidence, for the rest of his life. (I have lost three good jobs because of my police record.) If he had a crippled personality before, it will now begin to disintergrate.

However, the first few days at Leeds are beneficial to his physical condition; and he may acquire a feeling of well being, despite his deplorable mental outlook and his crushed ego. But after physical health has been restored, he can derive nothing but harm by continued incarceration at Leeds. For now the insidious degeneration of his self reliance begins.

Subtle Decline Of Self-reliance

At Leeds everything is decided for him. He does not have to decide what he will have for dinner, what work he will do, what clothes he will wear, nor when he will go to bed. He doesn't have to use his brain to make the smallest decision, not to mention anything like determination.

At first he resents such treatment bitterly; but gradually and unconsciously, he begins to accept this routine, and if he is sent to Leeds often enough and for long enough periods of time, he will prefer it. In his subsconscious mind he will prefer it because he has lost the ability to think for himself.

Finding It Easier To Drift

When he is sent back into the world he finds it is easier to drift—or to go back to the farm. He has become a halting, vacillating individual, incapable of making the most trivial decisions.

To quote William S. Sadler, M. D., chief psychiatrist and director of the Chicago Institute of Research and Diagnosis, "The strength of one's character is directly determined by, and is commensurate with, the number and magnitude of one's decisions."

And, "Indecision represents the fetter-irons which manacle and effectively hold down the strongest of human wills. No weak and trembling neurotic was ever able to exercise his own will and deliver his soul from the inertia and ennui of the nervous states until he had first conquered indecision and procrastination."

"Without The False Courage Of Alcohol"

The most vital lesson an alcoholic has to learn is how to face the realities and decisions of life without the false courage of alcohol. He cannot learn this lesson through forced sobriety or punishment.

Too much punishment tends to fix in the mind of the alcoholic the idea of his mistake and this seems to build up an evil obsession which respects such wrong behavior and in the end leads to repetition of the error.

If alcoholism could be cured or arrested by punishment there would be no alcoholics. No torture ever devised by man can equal delirium tremens.

Alcoholics Anonymous have done wonders with this problem, but even they find little success in aiding the alcoholic who has become "institutionalized" by too much Leeds' routine.

FUTURE FARE

Ready for the November INVENTORY are these interesting features:

Questions Ministers Ask About Alcoholics—A vivid series of questions and answers compiled for INVENTORY by Duke University's Dr. Russel Dicks, national authority on pastoral counseling. According to Dr. Dicks, "The ministers who have raised these questions have belonged to all the major denominations."

Rowan County Blazes A Trail—The story of Rowan County's unique program of alcohol education on "the harmful results from abuses of alcohol." By Peter P. Cooper, energetic young director of the new venture.

Another Turn Of The Screw—A feature on the Occupational Therapy Program now being conducted by the Butner Alcoholic Rehabilitation Center. A story of emotional needs met through manual therapy.

Self-expression Through The Soil—A convincing article on the therapeutic value of gardening presented to INVENTORY by Dr. Orin R. Yost, Orangeburg, S. C., Psychiatrist-in-Chief at Edgewood Sanitarium Foundation. "A garden is unquestionably an opportunity for self-expression by the work of one's own hands and by nurturing living things."

"MY MOST CHERISHED ASSET"

Months Of Sobriety In A.A.

I had been in and out of Leeds for five years when I began to try to salvage myself with the A.A. program, in 1945. Due to this program, I have known many precious months of sobriety. I have had two happy and sober interims of seven months each.

But when ill health, indecisions, and responsibilities accumulate, I am confronted with the torments of a dual personality. My mind becomes a battleground of conflict and each personality tries to annihilate the other. One of these antagonists is a fool—but a powerful fool—for whenever the conflict gets to a certain fervid intensity, the fool wins the battle and I accept the promptings of this fool to seek an escape in alcohol.

Vicious Battle Of A Dual Personality

My emotions at this time are ambivalent and impossible to describe. But suffice it to say that as I lift the first glass to my lips, I am both revolted and elated. Revolted by the knowledge that I am discarding sanity, good health, and high ideals.

I am poignantly aware that this simple act can only lead to intense suffering and jail. I am revolted by the knowledge that I am now powerless in the grip of this compelling force. Yet I am elated to know the conflict is over. Elated that I shall have respite from responsibilities and shall not be harassed by the necessity of making decisions.

Still Seeking Her Solution

I am still seeking a solution of my problem. If I were to give up hope of ever maintaining a permanent sobriety, I should then become like a few other women I know; a permanent resident of Leeds, except for an occasional few days of floundering drunkenness. Therefore, this hope is my most cherished asset.

However, I have been sent to Leeds so many times in the past nine years, that I, too, have formed the Leeds' habit. After I have started drinking, I no longer feel the least responsibility about getting sober. The police have settled this question for me so long that I have come to depend upon them; and I cannot exert the least effort toward getting sober, of my own will and accord.

A Law Guilty Of Grave Error

In forming long police records for alcoholics, and thus crippling

their ability or rendering them totally incapable of any permanent rehabilitation, the law is guilty of grave error.

I can remember when the police would drive a "drunk" to his home, unless he was too drunk to give them his address; in which case he was locked up overnight, for safe keeping.

If this course of action should be resumed, it would, undoubtedly, mean an early death for most of us who have become victims of institutionalism. Only those with latent powers of will and strength could survive.

But, all those alcoholics, who have not yet become burdened with police records, would still possess their chances of recovery. This plea has been made on their behalf.

From an anonymous letter in A Citizens Committee Report on Alcoholism in Kansas City, Missouri.

A NEW OUTLOOK THROUGH BUTNER

Name: Butner Alcoholic Rehabilitation Center

Space: Beds for 50 men patients.

Requirements: Social history of each patient, giving family and educational—vocational background. In addition, the medical history of each patient, giving the necessary physical background and condition.

Social History: To give the doctor a foundation for diagnosis and some guidance toward sobriety. The best compiler is the trained case worker.

Location: Butner, N. C., 30 miles northwest of Raleigh.

Cost: $72 for 28 days treatment.

Treatment: Group discussions led by Medical Director, educational films, individual consultations with the doctor, vocational therapy class, recreation and rest, much good food and any prescribed medications.

Discharge: Patients are referred to the family doctor, mental hygiene clinic, and Alcoholics Anonymous. ARP follows progress of each patient.

A leading factor in the successful treatment policy of the Butner ARC is the social history required of every patient. According to ARP Director, S. K. Proctor, "This outline is not to be written on or used as an application blank. It is merely a list of the items about which we need information. The case worker should use the outline as a guide for drafting her report in regular paragraph form. County Welfare offices supply these forms."

Dr. Lorant Forizs, ARP medical director, adds, "These social histories are important. They save time and give us information the patient won't readily admit at first. The best compiler of these histories is the trained case worker. The ones developed only by the patient and his family are usually very ineffective. When we get a full environmental-educational-vocational background of the patient, the process of treatment is much more effective."

TREATMENT IS VOLUNTARY, DESIRE IS COMPULSORY

Which Comes First – The

Work from several laboratories during the past few years indicates a long overdue attitude of curiosity about the nature of alcoholism.

As long as there was contentment with the application of moral or purely sociological and descriptive aspects of alcoholism, the patient suffering this disease was doomed to languish in it. However, now that there is scientific interest concerning the mechanism by which this disease is produced and perpetuated, we may look for great strides in the elucidation of its nature.

The work from Dr. Diethelm's laboratory is part of the new era in the study of alcoholism: an era which should see real progress into the causes and treatment of what some people consider to be the fourth in importance of our major public health problems.

Much of the lack of interest in alcoholism has been caused by lack of new and rewarding approaches to the problem. In the past, treatment has been so generally discouraging that few physicians have interested themselves in this medical problem.

A Challenge To The Medical Profession

Indeed, the first major modern approach has been on the part of the lay public. To have what is generally considered a disease so neglected that lay forces find it imperative to rush in to fill the void is surely not to the credit of the medical profession.

The work from Dr. Diethelm's laboratory raises a number of interesting questions, and points the way for much further investigation. It would be interesting to apply this technique to animals in which states of frustration and anxiety have been developed by conditioning, and in which an appetite for alcohol results.

The fundamental fact about alcoholism is, that it is a disease, and that it has, therefore, an etiology. There is no effect without an adequate cause. Does this work give us the adequate cause for alcoholism? I think not. There must be some factor, probably a common denominator in alcoholics, which operates in the presence of resentment, or tension or anxiety.

For surely, as Dr. Dienthelm's work in the past has shown, not all resentful people are alcoholics, and there would appear to be far more tension and anxiety in the world than there is alcoholism. But these emotions do seem to act as trigger mechanisms in producing particular episodes of drinking.

A possible common denominator here is hypothalamic function, with consequent fluctuations in overall autonomic nervous system activity. Certain findings in chronic alcoholics, the most striking of which are sleep and

PLANS FOR GROWTH . . .

Requests for the July edition of INVENTORY have surpassed the regular circulation list. Current plans are to raise this month's printing from 7500 to 9000, with an eventual total of 10,000 to insure adequate coverage for those citizens requesting copies of the journal.

The ARP's director, the journal's editor and staff are deeply grateful for the response this publication has received.

motion Or The Chemical?

appetite disturbances, suggest that a hypothalamic disorder may be present in chronic alcoholics.

We reported to the 2nd Clinical ACTH Conference our findings in a series of 73 chronic alcoholics subjected to the standard epinephrine and ACTH eosinophil response tests. Whereas 34% had a negative ACTH response, 75% had a negative epinephrine response. This suggests the possibility that in the chronic alcoholic the inadequate epinephrine response may be due to a pituitary or hypothalamic defect.

In studying this effect we administered epinephrine alone, and epinephrine and alcohol concomitantly, to approximately 20 chronic alcoholics. It was interesting that whereas the usual adrenaline effects of nervousness, tremor and anxiety were produced by epinephrine alone, in the majority of these patients, these adrenaline effects were usually abolished or greatly diminished when 50 grams (approximately 5 ounces) of alcohol, as beverage whiskey, were given concomitantly.

A Fascinating, Fundamental Question

Many of these patients stated that the "shakes" they experienced following adrenaline were identical with the "shakes" that led them to take alcohol. It is important to note that, although the subsance which Dr. Fleetwood finds present in states of anxiety is thought to be nor-adrenaline, nor-adrenaline itself, when injected, does not produce the characteristic symptoms of anxiety as adrenaline does.

The fascinating and fundamental question is, which comes first, the feeling of resentment, or the increased titer of a chemical substance as determined by bio-assay.

In other words, does the emotion produce the chemical, or does the chemical produce the emotion? We must consider the possibility that the emotion or behavior disturbance is a reaction to a chemical disturbance in the internal environment, as well as the possibility that the emotional disturbance produces the biochemical change.

Furthermore, it is possible that the increased titer of humoral substance is a mere concomitant of the emotion. That is, does the patient drink to abolish the resentment, or to reduce the titer of the humoral substance?

Since it is our opinion that there is a fundamental necro-endocrine defect in alcoholism, it is interesting to see this work from Dr. Diethelm's laboratory.

By James J. Smith, M.D., Department of Medicine, New York University—Bellevue Medical Center

. . . AND FUTURE SERVICE

In addition to raising the state-wide circulation coverage, the ARP hopes in the near future to re-work the July edition into a comprehensive brochure devoted exclusively to the Butner Alcoholic Rehabilitation Center and its unique program of treatment and rehabilitation.

These plans also are being made in answer to requests from professional and private citizens interested in the Center.

RECREATION PLAYS A NEEDED PART

During the summer, the Alcoholic Rehabilitation Center at Butner has conducted a versatile recreational program for patients who desired to participate. F. Norman Bowles, Durham native and pre-medical student at the University of North Carolina, directed the program.

In the words of Bowles, "There is such a wide range of ages at the Center that we have had to adjust our recreation to each group. Walking is a popular exercise. Many of the men take long walks in the afternoon, going in groups of two or more. Some of the older men get adequate exertion this way."

The Center has provided swimming twice a week, on Thursday and Saturday, at the Butner public pool. Croquet on the lawn in front of the Center is a popular recreation with the patients. There are also horseshoes, volley ball, and softball facilities.

In the lounge there are various indoor games, table tennis, a billiard table, and a growing library. Since Bowles came to direct the program, two features were added for the summer: periodic old-fashioned ice cream freezings and outdoor wiener roasts.

In the Center's over-all scheme of treatment, such recreation gives the patients a combination of physical and emotional rest greatly needed by most of them. The Center's spacious, attractive lawn is often the scene of late afternoon sessions which strengthen the ARC's fellowship.

As one patient put it, "For the first time since I can remember, I pitch into a game or just a bull session without feeling so darn self-conscious and inadequate. It's good to feel natural and to learn to be that way."

THROUGH BI-WEEKLY VISITS

State Employment Service Offers Helping Hand To Butner Patients

By W. L. CHRISTIAN
And AMANDA DAVENPORT
N. C. Employment Office, Durham

The assignment to make bi-weekly visits to the newly created Alcoholic Rehabilitation Center at Butner for the purpose of offering job assistance to the men who go there for treatment, opened up new ground for me and for the Employment Service in North Carolina.

On the nine visits I have made to the Center since the beginning of our part in this program on April 25, 1951, I have made only enough progress to discover what the possibilities of the assignment might be.

Laying Of Tentative Plans

It is already clear to me that the greater part of the results and rewards will have to be measured by some yardstick other than actual placements made—if they can be measured at all by statistical methods. This needs some explaining, but before I go into that, I think you would be interested in how the Employment Service "got into the act."

It all began back in March with a visit to the Local Office from Mr. S. K. Proctor, Executive Director of the N. C. Alcoholic Rehabilitation Program. He and Mrs. Ethel C. Lipscomb, Manager of the Durham Office, discussed tentative plans for putting on the program of helping these unfortunate men to have job prospects when they are discharged at the end of the 28-days treatment.

ARP Contacts All Employment Offices

Following this visit, Mrs. Lipscomb discussed ways and means with the local office staff. We all felt that it would be worthwhile, but would require the cooperation of all the local offices in the state. She wrote Mr. Proctor assuring him of our willingness and desire to cooperate with them in any way possible, and referring to his plan to inform other offices in the state about the program.

When we received a letter from Mr. Proctor, it was plain that he had not allowed any grass to grow under his feet, for he enclosed a copy of a form letter and enclosure he had sent to all Employment Service Offices in the state.

Along with his form letter requesting the cooperation of other offices and telling them of our plan to interview the patients, register them, and forward the cards to the areas of their choice, Mr. Proctor sent a release written by Mr. Santford Martin, Jr. Educational Director of the Alcoholic Rehabilitation Program.

"IMPRESSED WITH THE SET-UP"

Where The Employment Service Comes In

This article, entitled "That's the Catch," advanced the proposition that the town drunk is really a sick man and that North Carolina is now recognizing that fact and trying to do something about it. Where the catch lies is the preparation of the patient for the assumption of financial responsibility. Of course, that usually means a job—and that's where the Employment Service comes in.

In his letter to us, Mr. Proctor said that the response from other offices has been pleasing, and asked whether we still felt that we could send an interviewer to the treatment center for part of an afternoon every other week.

The manager and supervisors then got together to make practical plans and to select someone to do the actual work of interviewing. Then they discussed it with me and asked for suggestions. Being an old military man, I saw that I was about to be drafted—so I volunteered.

Learns Basic Philosophy Of Butner

Seriously, I felt that it was a very worthwhile project that would be a challenge to any man, and I accepted the responsibility for that reason.

On my first visit, I was very much impressed with the set-up. I learned from Mr. Keith, Chief Attendant, that the patients seek treatment at the center on their own accord; that there are no gates, no guards, and that the treatment lasts for 28 days.

Their quarters, located at 41 Central Avenue, are clean, roomy, and well-furnished. There is a large recreation room, a well-lighted and attractive dining hall, good food. The patients said that they received excellent treatment, had gained weight, were feeling better, and were enthusiastic over the results of the medical treatment they had received. The patients have free association with the staff, and with each other. The atmosphere is more like that of a good club than anything else I can think of.

"They Had Plenty Of Questions"

I talked to a group of 22 patients on that first visit, explaining the purpose of the program and inviting questions. They had plenty of questions—about job openings in other localities, unemployment compensation, on-the-job training, and general subjects relating to jobs. At the end of my talk, I invited all who needed help in obtaining work after their release from the center, to see me in private.

A private office was provided for me. Of the seven interviewed that day, five wanted work in places other than their home towns. I registered the five: an electrician, a civil engineer, a market supervisor (food), a supervisor of tobacco inspectors, and a salesman.

They were undecided as to just where they wished to locate, so I decided to try to help through use of the Job Inventories on my next visit. Those who were interviewed said they were pleased to know that some agency was trying to help them.

JOB-COUNSELING INVALUABLE

A Part Of The Curative Process

The description of my first visit to the center is fairly representative of all visits made. Since each patient is there for only 28 days, there are usually only two contacts per patient. The first interview is not very productive from the standpoint of job placement, and can thus be considered only a part of the curative process in the boost to his morale that it may afford the patient. The patient is often in no condition to be interviewed during the first week or two of his stay. He is uncertain of what he wants, and is doubtful of his capabilities.

As I hinted in the beginning the results are likely to be more intangible than those of the usual local office activities. The main tangible service our program is able to render is in registering the applicants, and sending the cards to the office of their choice, writing letters for the purpose of securing job information, counseling the patients on choice of jobs and on work attitudes.

Results Beyond Statistical Measurement

It would be nice if I could report that a bang-up job of placement is being done, but that is not the case, nor is it likely ever to be. There may be some possibilities of clearance placements in defense work as times goes on, I believe. Two or three have already been reported on clearance as available applicants and several registration cards have been forwarded to other offices in the state.

In a recent conversation with Mrs. Lipscomb, Mr. Proctor observed that he considered the results of the whole rehabilitation program so intangible as to be beyond statistical measurement. He stated that he considered the job-counselling, and the interest shown in the patient (who usually feels that the whole world is against him, anyway) are of inestimable value.

"Like A Cross-Section Of Friends And Acquaintances"

He went on to say that some of these men are definitely in the wrong work, and that that is part of their problem. When asked whether he thought the program thus far had had any good effect on the men, he was very enthusiastic and said that he could vouch for that. He said it was a great comfort to these men to know that someone is taking interest in them.

The notes concerning work history and the personal data that I take down each week when I talk with these men read like a cross-section of the friends and acquaintances one meets on the street everyday. I feel that, regardless of whether I or this office can ever point to any imposing list of placements, the program is worthwhile.

The real appreciation shown by the patients, and the obvious lift it gives to their spirits, to be made to feel that there is a place for them in the normal workaday world, is well worth the relatively little time and energy it may take.

Tar Heels Take Dramatic AA Jaunt Through The Canyons Of Manhattan

While attending Yale's Summer School of Alcohol Studies this year, a group of North Carolina students arranged a tour of the national headquarters for Alcoholics Anonymous and other pioneer alcoholic facilities in New York City.

The first stop was the famed Alcoholic Pavilion of Knickerbocker Hospital on 131 Street. There the group was met by L. B. Dana, Knickerbocker's administrator, and Teddie Rohan, head nurse for the alcoholic division.

A tour highlight was the visit to "Duffy's Tavern," largest ward and assembly room on Knickerbocker's alcoholic floor. The North Carolinians spent 20 to 30 pleasant minutes meeting and talking with "Duffy's" patients, brave men with big hearts and even bigger hopes for recovery.

By cab down Lenox Avenue through the heart of Central Park and a few blocks east of Times Square, the Tar Heels landed Yankee style in the center of the friendliest national headquarters a southerner ever "accented upon." The General Service Headquarters of Alcoholics Anonymous is also the home of *The Grapevine,* international monthly of AA.

Here the group was met by a very cordial New York AA and former Tar Heel who took over the tour. The national staff was made up largely of AA's in various administrative duties, from world-wide correspondence and national intergroup counseling to public relations and magazine editing.

From headquarters, the students went to the AA Intergroup office on Lexington Avenue. Here was explained the office's link with the city's various AA groups and clubs. Telephones jingled, staff members answered all questions relative to meeting schedules, sponsorship for patients needing hospitalization, any questions relative to AA. Neatly bound rosters open only to AA's told a story of human lives salvaged by AA.

On the upper edge of the Bowery, nine Carolinians labored up four flights of dimly-lighted stairs to a Twelfth Step House with a kitchenette and a manager long acquainted with the neighborhood and its people. Chairs were arranged "meeting style." Food was available to the hungry, clothes for the ragged. A mixture of hope and hopelessness hovered humidly over the room.

Two men, transits passing by, sat in opposite sections of the meeting chairs. They looked searchingly at the floor, then squeezed their AA pamphlets into a tight roll between their fingers, glanced swiftly toward and away from the visitors, finally rested their eyes upon the sign above the speaker's desk. The sign said, "But for the Grace of God."

Down the stairs across the cobbled street into the shadows of elevated tracks the students rushed behind their guide. For the next seven blocks, they walked slowly, sometimes hesitantly, nearly always self-consciously through the streets and alleys of New York's Bowery of legends where men go to forget and to be forgotten.

A man in an Indian suit-affair rushed up to the two rear students. His left eye leaked a puslike fluid as he mumbled something about money to buy a cart so he could make enough money to buy some cardboard to sell like

North Carolina students leave the world's first A.A. clubhouse, originally the apartment of Bill W., co-founder of Alcoholics Anonymous who reached his hour of decision while living there in the thirties.

On the first row, left to right, are Dick Moester of Winston-Salem; Mary Ruth Davis, Robbins; Bob Denny, Salisbury; and Dave Cox, Raleigh. On the steps are Ralph Monk, a Tar Heel of New York City; Charles Auman, Butner; Dorothy Ennis, Greensboro; and Jane Latham, Charlotte.

a man with a business of his own. His breath spoke for itself. Both students handed him a coin and squeezed closer to the group.

Out of the Bowery into the world's first AA clubhouse is a long journey, not in miles, only in spirit. The group became more relaxed, less tense with human tragedy. Here was the hide-away-door with the odd address—334½—wedged between two old-fashioned brickfronts. Here was the modest apartment in which the co-founder of Alcoholics Anonymous had lived when he reached his hour of decision in the middle thirties.

To look upon the portrait of Bill W. over the neat mantle was to see the good in man raised triumphantly over the bad in him by his Creator. Here was the long tunnel-like entrance corridor Bill had named "The Last Mile." The students signed the Club's register and stood at the door for a picture.

In a matter of blocks, they were shown another Twelfth Step Workshop, more of an uptown one, the Alanon House, midway of Hell's Kitchen and Broadway in the heart of the Roaring Forties. There were no endless stairs, but there were a meeting room, a kitchen and the same problems, the same unique fellowship in less ragged clothes, the same symbol over the counselor's desk—"But for the Grace of God."

The tour ended a block or so east of Riverside Drive in the late afternoon shadows of the Hudson, as the personable AA volunteer-guide wished the Tar Heels a safe return to Yale's School of Alcohol Studies, where research locks hands with reality.

INVENTORY

If we are to understand the illness of alcoholism, we must take an inventory of what we know and don't know about beverage alcohol and human personality.

If we are to solve the problems of alcohol, we must identify ourselves with the illness of alcoholism. Major and *curable* maladies of today were considered incurable for years, until society chose to tackle them rather than avoid them.

Such identification takes teamwork. It takes the hospital and its physician, the church and its minister, Alcoholics Anonymous and its experience, the family and its newspaper, the public school and its teacher, the radio and its public forums, the health, welfare departments and their trained case workers.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

Miss Carrie L. Broughton, Librarian
State Library
Raleigh, N. C.

INVENTORY

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

Published By THE N. C. ALCOHOLIC REHABILITATION PROGRAM

Vol. I NOVEMBER, 1951 No. 4

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TREATMENT REHABILITATION EDUCATION PREVENTION

INVENTORY
A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

VOL. 1 NO. 4

NOVEMBER, 1951

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices, 429 Agriculture Building, Raleigh, North Carolina.

S. K. PROCTOR.....*Executive Director, ARP*

SANTFORD MARTIN, JR.....*Editor - Educational Director*

LORANT FORIZS, M. D.....*Medical Director, ARP*

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C., UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

A TYPICAL VICTIM

There was a long, lean, sinewy simplicity about him. You could see the sickness in his eyes, insolence mellowed almost into humility. He was tired, and the lines in his forehead, out of his eyes, across the cheeks into his mouth were deeply furrowed with bitterness, dimly shadowed by years of disappointment.

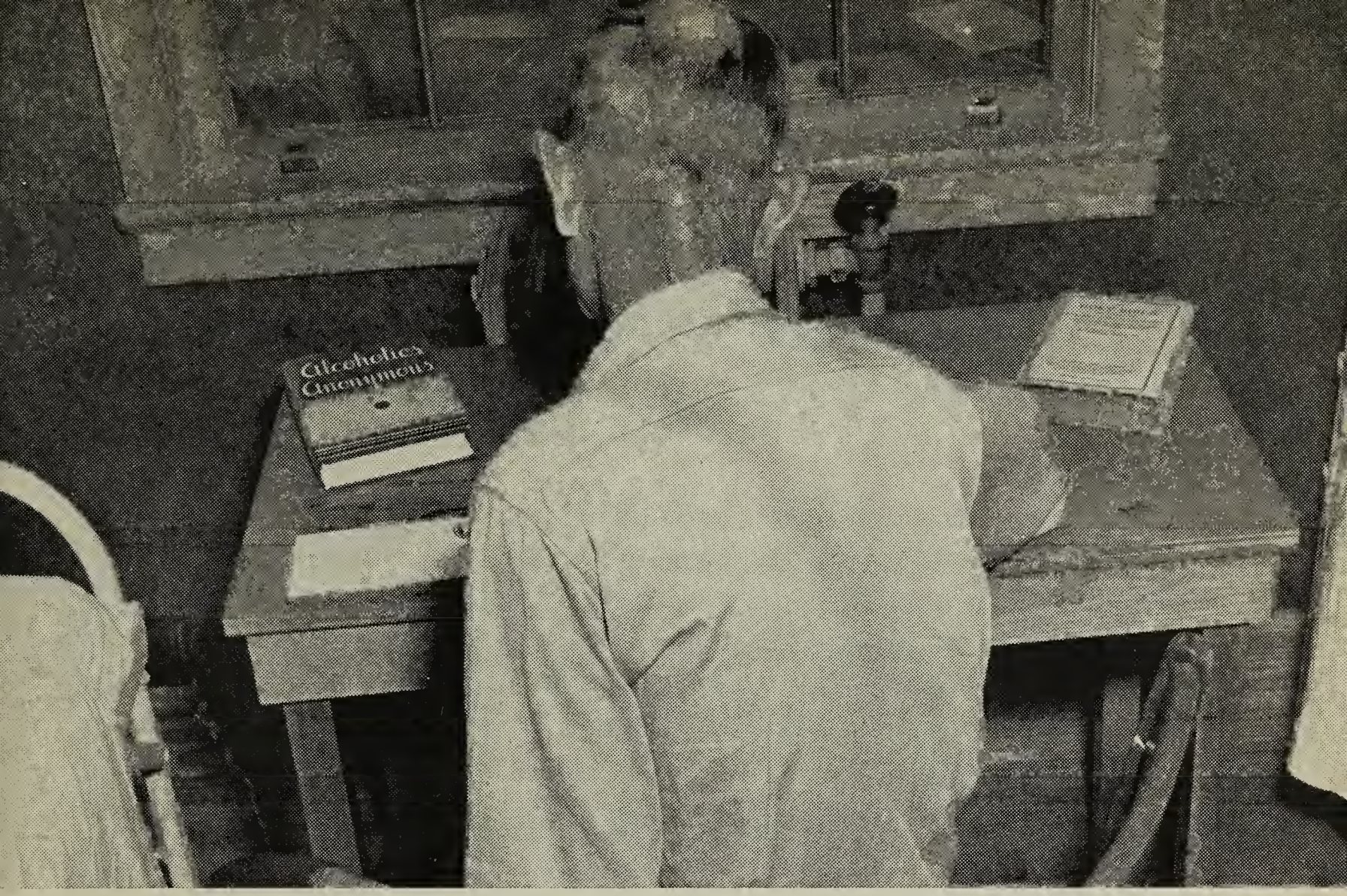
Gray hair grew thin on his head and faded away between the leathery wrinkles of his neck. His lanky frame moved obediently at each request of the doctor and the Butner attendant. He was a most obliging person, willing to do anything the ARC staff asked of him. He was sick and he wanted to get well, and Butner was a place of restoration, he had heard.

He was an alcoholic, not a typical one because there are no typical alcoholics. Alcoholics are human beings, and there are no typical human beings. He was an individual personality with certain traits as original as the earnest questions in his eyes.

In one sense, though, he was typical. He was a typical victim of provincial stigmas that brand his kind with the scarlet letters of Drunkard. Drunkard! Drunkard! For over ten years he had heard those words behind his back, out of the shadows of community righteousness. For a decade his eyes had shifted in frantic quest of someone who could tell him Why.

Everywhere there were people, friends, neighbors, relatives who could tell him he was wrong. How many times had he been told he was a failure, a weak, miserable failure with no will power? He couldn't count the times. How many times had he felt the sickness of not being wanted because of what the community had decided he was?

One man, a doctor, had once told him he was sick and needed help. The idea made him laugh. He wasn't sick. He was a weak, miserable failure with no will power. A drunkard sick? The community would laugh louder than he over that idea. Whoever heard of such a thing? A hospital for a drunkard? A gutter! That's where he belongs! A gutter where he can grovel in his own failures and weak-livered stupors.



Who cares, anyway? The family cares, of course, a community friend or two are concerned. The community folks mean well, but there's something vicious about good intentions that always end in judgment and condemnation. The sufferer finally yearns for a friend who stands neither above him nor below him but always beside him.

The Butner attendant shook his hand, took his bag, showed him to a room, then to the bath facilities, the dining room and the main lounge. He was introduced to a few of the patients who were reading or resting by the radio after lunch. One patient offered to play a game of table tennis. He didn't know how. The attendant asked him if he would like to see the workshop and movie room in the other building. He said he would like to see them. His mouthlines moved upward in cautious smile.

Three weeks later he sat down to write a letter to a long-estranged son. He wrote to say hello, to tell his boy he was thinking of him and was proud of the way he was succeeding. No doctor or minister, no one but this man of furrowed brow could write the last paragraph of this hopeful letter to a grown son long ago humiliated.

"They've got a funny way of treating failures like me at Butner. They don't laugh at you. They don't cry over you.. They treat you like a sick person, in a way, but a manly kind of way. They don't look shocked when you tell them what you've done. They don't seem to mind sitting beside you and talking natural-like about the past, about anything on your mind. It doesn't seem to embarrass them to be seen with you. They're good folks, but I don't guess people back home would know what I mean or exactly believe me."

The people back home are learning more each day what this man of long, lean, sinewy simplicity was trying to say.

Duke Professor Interprets Fourteen Popular Questions About Alcoholics

By Russell L. Dicks, D.D., Litt.D.
Duke University

These questions are based especially upon twelve four-hour seminars for ministers conducted through the Spring months in Western North Carolina and six throughout the state of South Carolina. The ministers who have raised these questions have belonged to all the major denominations. I have arranged the questions not in the order of frequency of occurrence, but rather in a progression of thought for purposes of a more understandable discussion of the subject.

A Relatively New Concept

1. *What is an alcoholic?* An alcoholic is generally defined as: a) one whose drinking interferes with his normal living; b) after taking a first drink, he cannot stop. Enlightened physicians and other careful students of the problem consider the alcoholic a sick person.. This is a relatively new concept. Note that the above definition makes no references to what the alcoholic drinks nor how much; these have nothing to do with the basic problem so long as he is drinking alcohol, that is, beer, wine, whiskey, or other alcoholic beverages.

2. *Can An Alcoholic be helped?* Yes. When I was beginning my work at the Massachusetts General Hospital, in Boston, in 1933, we were told in the psychiatric clinic, "You have not gained your spurs as a counselor until you have broken your heart over one drunk and one dope." The implication being that you would break your heart and that you would not help persons with these problems. Later I remember a doctor saying, "The minister should try to help alcoholics. Suppose he helps one out of fifty, it is worth his effort."

Impressive Figures From AA

The work of Alcoholics Anonymous (A.A.) has proven the above first statement false. Fifty per cent of those who take the A.A. program seriously stop drinking and another twenty-five per cent improve. Ten per cent of those who drink excessively are believed to be feeble-minded and another ten per cent psychotic; that is, they are suffering from serious mental disturbance. These people can be helped by treatment of the mental disturbance.

3. *How can you get an alcoholic to accept help when he has not sought your help?* This question turns upon the above, for you will note that I said *those who take the program seriously* are helped, those who look at the program and walk away are not helped. One of the major hurdles the alcoholic must cross is to admit that he is an alcoholic. This many will not do.

"What Is It To Want Help?"

It is often said of alcoholics, "Those who want help can be helped." This is probably an over-simplification. What is it to *want help*? How does one reach that point? The A.A.'s say through suffering, through "hitting bottom." They are careful not to define closely what "hitting bottom" is, or where the exact bottom is; naturally, it varies with individuals. One has a greater capacity to suffer than another; one has a greater resentment and feeling of hostility than another; one has a greater feeling of inferiority than another. These are a few causes of excessive drinking, not all, by any means, but important ones.

Two Allergies Of The Alcoholic

The process of suffering, which means suffering for others as well as oneself, and often premature death can be shortened in some instances by the minister through gaining the individual's goodwill and through his coming to feel that you are interested in him. This is no easy matter, however. The alcoholic is allergic to two places: a jail and a church, and he is afraid of two persons, both for the same reasons: a police officer and a minister. This fear grows out of his own feeling of guilt. Naturally, he will resist the efforts of the minister to gain his goodwill and friendliness.

4. *Would you talk to a husband who is drinking excessively because his wife asks you to do so?* It depends upon the circumstances. If there seemed to be some reasonable chance of helping him, I would. After all, we have a responsibility to be of help if we can. The least we can do is to offer help. When this is done in a non-critical way, it is often appreciated.

Will Often Respond To Understanding

I do not mean that one should show some aggressiveness; some people are impressed only with aggressiveness. However, aggression is not the proper approach to the average alcoholic. Most people abuse and criticize him. He will not respond to criticism, but often

he will respond to understanding. Even when there is no immediate response to understanding, the alcoholic may remember your interest and come to you later.

5. *How much help can you be with an alcoholic who wants to talk while he is drunk?* Very little. However, it is important not to reject him by refusing to listen. He will remember enough to know that you were not interested in him while he was drinking. It is desirable that you can have at least two non-drinking alcoholics upon whom you can call in such instances. You can explain to the drinker that these are friends of yours who will help him and that you will see him later when you will have more time.

Working With Alcoholics Anonymous

6. *How can the minister work with A.A.'s?* (Alcoholics Anonymous) By establishing contact with the A.A.'s through your local telephone or post office, and by attending their open meetings which will enable you to get to know them. Once you have established this contact you will be able to refer alcoholics to them and they will call upon you. There are some persons who will talk with a minister who will not go to A.A.'s. It is necessary for you to work with such a person for a considerable period of time, four to eight interviews, before he will go to the meetings and affiliate with the A.A. program. The alcoholic, however, needs the fellowship of the A.A.'s, where he can spend time with non-drinkers, and where he can begin to help others and thus get outside himself.

"From Stew To Steward In Two Years"

7. *What is the attitude of A.A.'s toward the church?* Alcoholics Anonymous have no attitude or stated platform as such and, therefore, it cannot be said that they have a stated attitude toward the church. Actually, however, the individual members are pro-church and many of them hold important positions in the church. I met a man in South Carolina who had recently been elected to the Board of Stewards in his church. Two years previously he was drinking excessively. He said, "From stew to steward in two years."

A non-drinking alcoholic said in one of our meetings, "The church must come part of the way in meeting the alcoholic. He cannot go all the way." Perhaps we in the church have not known how to go our part of the way in reaching the alcoholic and helping him to feel that we are concerned about him. Basically he feels rejected

already; therefore, he cannot force the possibility of further rebuffs, so he is not apt to risk rejection or snubbing by the pastor or by the church members.

In the A.A. meeting the alcoholic is taught to depend upon God. Many do not know much about God, and since Alcoholics Anonymous is a lay movement there are few of its members who are trained in the study of God and prayer. Many of them turn to the church readily and eagerly for help at this point.

The Drinker Must Seek Help

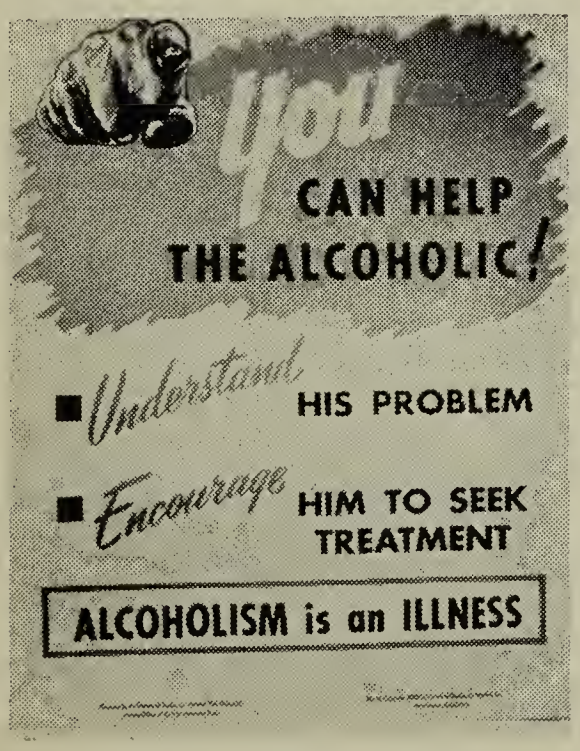
8. *Will the A.A.'s go to an alcoholic or must he go to them first?* The practice of the A.A.'s seems to vary in this respect, some will and some will not. The general attitude is that the drinker must want help and must demonstrate his desire by seeking help. I am sure, however, that if a minister should ask the A.A.'s for help with a given excessive drinker that they would respond readily.

9. *What is the major cause of alcoholism?* This question should

— THE LONESOME ROAD —

The ARP recently secured North Carolina rights on a new radio series dramatizing the way of the alcoholic. Written and narrated by Gunnar Back, the series was produced by the Columbia University Communication Center. Appropriately titled The Lonesome Road, the eight 15-minute programs use the voices of alcoholics, public health officers, and law enforcement officers in telling:

Why alcoholism is an illness—What the alcoholic can do for restoration—What the community can do to meet this public health problem.



The ARP has eight sets of this series for immediate distribution to any local radio station or group of private citizens interested in using this public service. The series consists of the following programs: The nature of alcoholic illness; The first steps to recovery; Ways problem drinkers can get help; To help him if he wishes; A practical way to recovery; For the non-alcoholic; New drugs: an interim report; and Alcoholism and youth.

For this service, write The North Carolina Alcoholic Rehabilitation Program, 429 Agriculture Building, Raleigh, N. C.

be put, What are the major *causes* of alcoholism? Because there are believed to be many. The one major cause is emotional instability. Many if not most people who drink excessively are unable to handle life and its problems. They drink to build up their egos, whether it be at a party or before a business deal. They drink to forget unpleasant memories; and they drink to avoid unpleasant responsibilities.

A Gradual, Dangerous Drifting

Another major cause of alcoholism is the drift into drinking through taking social drinks. That is, there is a growing dependency upon the alcohol until the drinker loses his ability to leave it alone. This is one of the great hazards of social drinking; perhaps not the greatest, however; the greatest is the one mentioned above; emotional instability.

Another cause of alcoholism is a sense of defeat, discouragement, mental depression, which for many people is circular for no apparent reason, that is, the depression returns. There are believed to be many other causes of alcoholism that are not known and that have not been sufficiently described by students of the subject, but these are the known major ones.

Mental Hygiene Education Is Vital

10. *What about alcohol education for our young people?* Here I have had little experience, but the type of education that describes the hazards of excessive drinking seems to work with some and not with others. There is conclusive evidence that leads us to believe that this kind of education attracts some who have a deep resentment toward their parents and causes them to express their resentment through their own self destruction in excessive drinking. In other words the education works exactly opposite to that which it was meant to accomplish.

The most helpful education seems to be that which is planned along good mental hygiene lines. Alcoholics were first unhappy and frustrated children; therefore, we need to work with children, to give them the emotional security that will make them happy and reliable adults. The mental hygienist is concerned about two types of children; the overly-shy child and the overly-aggressive.

Case Histories Provide Some Evidence

Both of these tendencies can be traced directly to the home. Either may eventually become alcoholics unless help reaches them. It is

believed that if a youngster has the years of six months to six years in a happy, emotionally secure home, nothing can make him an alcoholic. This is probaby not true in most instances, but it makes good sense in view of the case histories which abound that point toward the above conclusion. The evidence is far from complete.

11. *To what extent is the alcoholic responsible for his drinking?* This is one of the most interesting questions to a minister, and one that they have the most difficulty in accepting. When one has become an alcoholic, that is, when he cannot keep from drinking, he is not responsible for his drinking, for he has become a sick person. He was responsible when he was fooling around with the stuff before he began drinking excessively, but once his drinking is out of control, he is sick.

No Longer A Free Person

He is no longer a free person. The evidence indicates that some are not and never have been free persons in that they could not make reasonable decisions. These are described by the psychiatrist as compulsive persons; persons who do not know why they do a thing. Nor can they keep from doing it. Not all compulsives are alcoholics by any means.

12. *Is it ever advisable for the wife of an alcoholic to divorce him?* It is sometimes advisable from the wife's and children's standpoint, and sometimes this experience is "the hitting bottom," discussed above. Sometimes it means further rejection and further loss of morale. The depressed alcoholic is dangerous to those he loves and to himself.

Try Not To Advise Divorce

It is never desirable for the pastor-counselor to advise divorce in any situation. If you advise it, it is your decision. The counsellee should always be helped to make his own decisions.

13. *Is alcoholism inherited?* There is no evidence to indicate that it is inherited. The fact that alcoholism runs in families is believed to be an environmental conditioning which is so subtle that it appears to be inherited tendency.

14. *What kind of mistakes do ministers make in dealing with alcoholics?* The most common is in telling and expecting the alcoholic to stop drinking. Your task is to help him rebuild his sense of dignity so that he can stop. Secondly, it is important not to pamper him and over-protect him. When he gets in jail, it may be desirable to let

him stay there until he is released normally. Do not give him money, although you may have to arrange for him to get food and other essentials. Do not be overly-severe with him either: that is criticism and rejection.

A Love Greater Than Our Own

The alcoholic has been described as the "leper" of this generation: an outcast who is criticized and belittled until his morale is broken. It is important that we be alert lest we, too, should pass by on the otherside as did the priest and the Levite who traveled the Jericho road in a story our Lord told about a good Samaritan. We would not like to admit that we "passed by" when a fellow creature was lying bloody and bruised and uncared for; it is love greater than our own that causes us to seek to help the alcoholic, to be patient with him, to be severe when severity is needed, to understand him, and to love him.

— AN EXACT REPRODUCTION —

In answer to requests, the January edition of INVENTORY will present an exact reproduction of the social history outline so vital in the diagnosis and successful treatment of many Butner patients.

Through this outline, the Butner doctor receives a full environmental-educational-vocational background from which to guide many patients toward permanent sobriety.

A leading factor is the successful treatment policy of the Butner ARC in this social history. Actually, it is an outline, not to be written on or used as an application blank.

It is merely a list of the items about which the doctor needs information. The efficient case worker uses the outline as a guide for drafting her report in regular paragraph form.

According to the Center's Medical Director, "These social histories are important. They save time and give us information the patient won't often admit at first. The best compiler of these histories is the trained case worker.

"The histories developed by the patient and his family are usually very ineffective. When we get a full picture of the patient's background, the real facts back there, we can give him much more help."

The value of a complete social history, environmental picture of the patient cannot be emphasized too much, according to ARP Director S. K. Proctor. It gives the doctor a foundation for diagnosis, something to work on.

ARC admission rules require a medical history and a social history. The medical history is secured through the family physician. The social history is secured through the County Welfare Department.

Special Collection On Alcoholism Circulates Among Local Libraries

In answer to requests for more information on alcoholism as an illness, the Alcoholic Rehabilitation Program has sponsored during the past nine months two kits of similar books and pamphlets giving the latest facts on alcohol and alcoholism and all related problems. These materials make up North Carolina's foremost library collection on the relatively new subject of alcoholism.

Consisting of 33 books, 91 pamphlets, and 39 reprints, the two informational kits are circulated by the North Carolina Library Commission under the direction of Librarian Gladys Johnson. The Commission is located on the fourth floor of the State Library in Raleigh.

Available for exhibit-informational purposes among public and private libraries, the kits are in popular demand by professional and lay groups throughout North Carolina. New materials are chosen by the ARP and sent in duplicates to the Commission for kit distribution.

Careful consideration in the choice of materials is given by the ARP staff. Since many areas of alcohol-related problems are charged with emotion, the ARP makes sincere efforts to choose materials based on scientific facts and realistic experience, materials free of bias.

Librarian Johnson has cooperated energetically in building the kits into a leading collection on alcoholism for North Carolina. The ARP purchases four sets of all materials—two for the Commission kits, one for Butner's Center, and one for the ARP Raleigh office.

Special Waiting List Maintained

This collection is available for all North Carolina libraries. According to Miss Johnson, "We would like to see the different libraries take hold of this service. It's for their use and we try to keep the circulation schedule set up to meet the various dates requested. The kit is sent to each requesting library for a month's stand. We maintain a waiting list to meet the requests of libraries that want the materials for specific, dated occasions.

"Local study groups, club programs and other civic efforts can be supplied these materials through their local library. When these books go into a county, city, or private library, they are used, of course, according to the policies and discretions of that library. The nature of the materials makes them a natural attraction. They certainly represent new effort and new facts in a field of old, unsolved problems. Local libraries can render a distinct service through these materials."

The opening months of this service have been spent in encouraging local libraries to use the kits only for display purposes. Current efforts are being made to encourage circulation of the materials among local patrons. The books and pamphlets are readily handled on a circulation basis, but most of the reprints are broadsides or two-page leaflets not easily distributed on a

wide scale. A basic ARP aim is to encourage local libraries to secure their own collections of these materials.

In most cases local interest in the collection is very satisfying to the participating libraries. One North Carolina county library with a division in its two leading towns had an interesting experience with the popular kit. The vividly-titled collection had been on display for a few days when a staff member noticed that some of the materials were missing. Immediately the librarian wrote the Library Commission for a price list on the missing literature.

"When No One Was Looking"

Preparations were being completed for necessary payment when the missing editions were returned anonymously, somewhat mysteriously to the display table—"when no one was looking." Whoever had borrowed the materials apparently had learned what he wanted to know, or didn't want to know. In the opinion of the ARP staff, such interest indicated a healthy desire for the latest approaches toward an old problem, but the method of use was, of course, quite unethical.

According to S. K. Proctor, executive director of the Program, the kits will be increased with the demands, and eventually the original display units will be supplemented by follow-up kits giving more specialized phases of this public health problem. Civic, community leaders throughout the state, doctors, ministers, professional and lay citizens alike are expressing daily interest in the new concept of alcoholism as a progressive illness.

These citizens want information, and the ARP considers its library service a beginning answer to many of these demands. The services of this collection can be secured by putting a request before your local library. The Library Commission at Raleigh will then be notified to provide the service as soon as possible. For a month, local patrons and groups will then have access to the ARP's collection of books, pamphlets, and reprints on the newest facts about alcoholism.

Service Has Covered Representative Area

Already this program has served the following institutional and community libraries: Bennett College, Greensboro; Appalachian State Teachers College, Boone; Fayetteville State Teachers College, Fayetteville; Warren County Memorial Library, Warrenton; Mitchell College, Statesville; Pineland College, Salemburg; Anson County Library, Wadesboro; N. C. State College, Raleigh; Rockingham County Library, Leaksville and Reidsville; Warren Wilson College, Swannanoah; Watts Hospital, Durham; and New Bern Public Library, New Bern.

The following list includes some of the materials now available in the ARP collection. They are given here with each publisher's address for any citizen or group that might want to add some of them to a personal or a public collection.

From her desk, Librarian Gladys Johnson of the Library Commission discusses the latest state-wide requests for the ARP's special collection of books and pamphlets on alcoholism. Library Assistant Gladie Bullard takes notes while Miss Doris Dixon, secretary to the Circulation Department, looks over one of the pamphlets. Hal Pope, Commission mailing clerk, secures one of the kit boxes in which part of the materials are wrapped for shipment to a local library within the state. Part of the kit is shown on the desk.

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Public Drunkenness – A Revealing

By Robert
Graduate Fellow,

Joe Tippler appears before the judge on a charge of "public drunkenness" about once a month. From time to time Joe is engaged in road construction, facilitating an easier and more comfortable passage for the good of the North Carolina motorist. The State may institutionalize him to re-build roads but what about proper institutional provisions to help him re-build himself?

Joe doesn't clear the right-of-way or dig ditches out of occupational preference. In fact Joe may be a skilled machinist or electrician by trade. Nevertheless, he has erred, the mores have been breached and he must pay.

People condemn Joe. They say he's no good for his wife and three children. They say he's a bad influence for the neighborhood. His old boss says Joe was one of his best men, but his company can't afford to keep men whose outside life interferes with attendance to the job.

An Increasing Cycle Of Deterioration

General condemnation by friends and relatives doesn't arouse Joe from his alcoholic tendencies. It only confirms his own conception of himself; that is, he feels inadequate in the face of daily demands made upon him as husband, father, breadwinner, or any of the numerous other roles he must play.

Deep back in Joe's mind he feels he has failed his wife, family or friends, that he is not man enough mentally, or physically, to live up to the expectations people place upon him. On the other hand, Joe has learned that by drinking alcohol he can dispose of that little nagging voice in the back of his head, if only for a short time. Hence he becomes involved in an increasing cycle of deterioration, the more he drinks the less he and others think of him.

We tend to picture this type of hypothetical alcoholic much as we would a child. The more we tell him he shouldn't do something, the more prone he is to do just that thing. So we must punish him more and more until we break his rebelling spirit.

The alcoholic doesn't rebel against his responsibilities, he retreats from them. Throughout his life he builds up conceptions of what

Study Of One City's Problem

E. Pace
University of North Carolina

he can and can't do. When he is confronted by a situation beyond his self-appraised abilities, his reaction is withdrawal by some known means. Some of us retreat through hypo-activity in some fields, some through alcohol, and some even escape through a form of insanity.

It isn't either the alcoholic euphoria or the stupor that presents the real problem. Rather, it is the particular construction of the more fundamental personality which seeks withdrawal through alcohol. Can we in good consciousness punish a person when the community and its families, schools, and churches have failed? If so, we have a large number of actual and potential road hands in the state. If not, let's reappraise the whole situation and start educating and re-educating to relieve the dilemma.

Signs Of How Many, Where, Who, Why

Most of us do not understand the extent of alcoholism. To get a better idea, a study was recently made in Durham of public drunks convicted by the Recorder's Court. Many of the alcoholics never reach the court, while many persons indulging only once or twice a year are apprehended. Thus public drunk convictions can't tell the complete story, but they do give a good indication of "how many", "where", "who", and "why".

It is a bit difficult to swallow, but there were some 10,954 convictions in Durham County, 1947-50! If that many persons indulged at the same time and decided to lie down end to end along the highway they would extend for a 12 mile stretch! To learn a little more of those convicted, names appearing on court records in 1947 were recorded and cases traced through the following four years. This was made possible by the excellent record system installed by Judge A. R. Wilson in 1947.

Excluding those convicted for driving while intoxicated and those living outside of the city limits of Durham, 1,163 were convicted for a total of 4,108 convictions. Each convictee averaged over 3.5 convictions for the four year period. As might be expected, males composed the greater part of the convicted population.

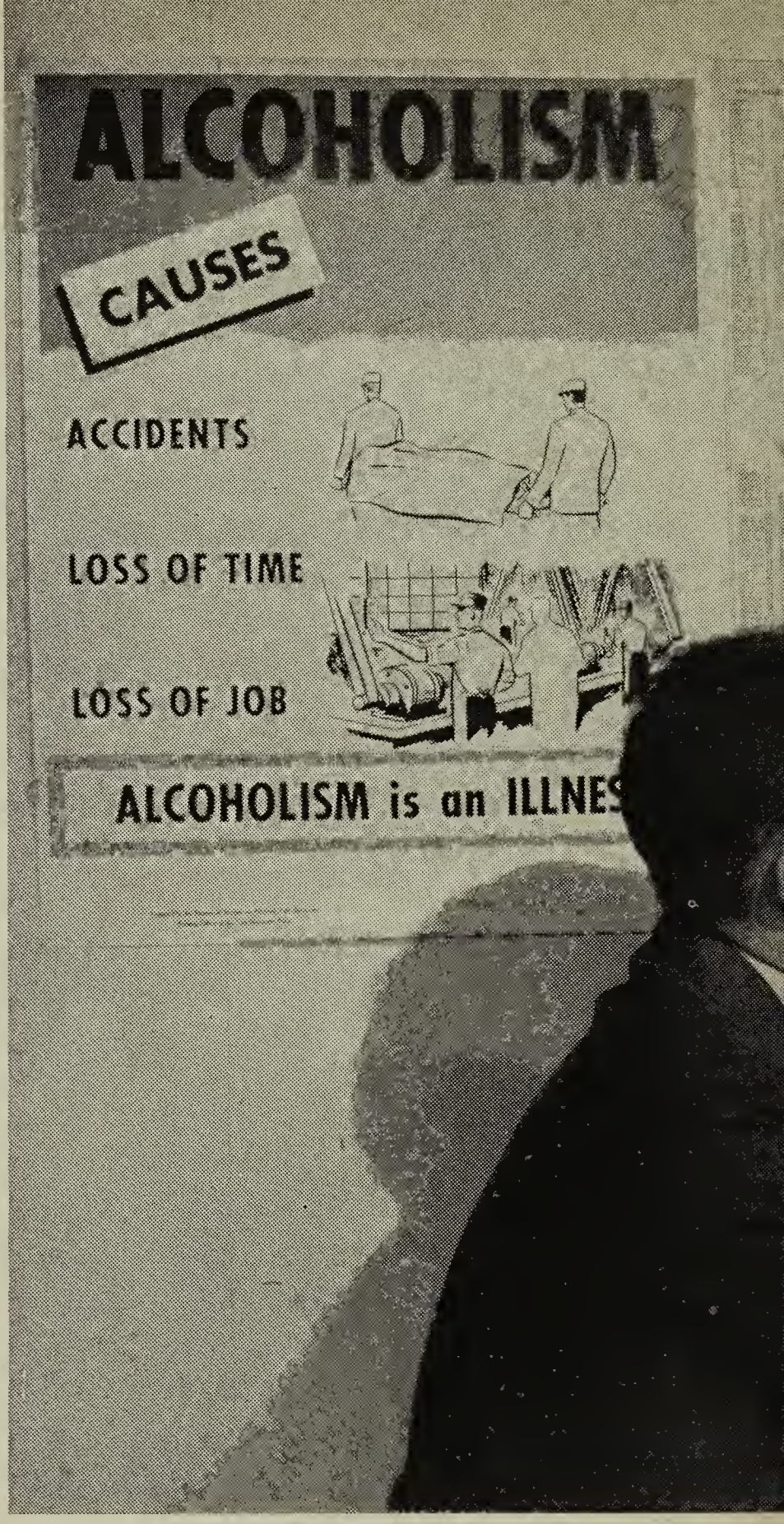
Approximately 92 per cent were males, and they averaged over

3.6 convictions, in comparison with 2.5 for females. In addition to more convictions, males averaged about 7 years older than females.

Contrary to popular thought, a greater number of whites than Negroes were convicted. Whites also averaged more convictions per convictee.

Approximately 65 per cent of the population of Durham is white, yet 67 per cent of the convictees were white. The average convictions per white convictee was 4.1, for Negroes it was 3.6.

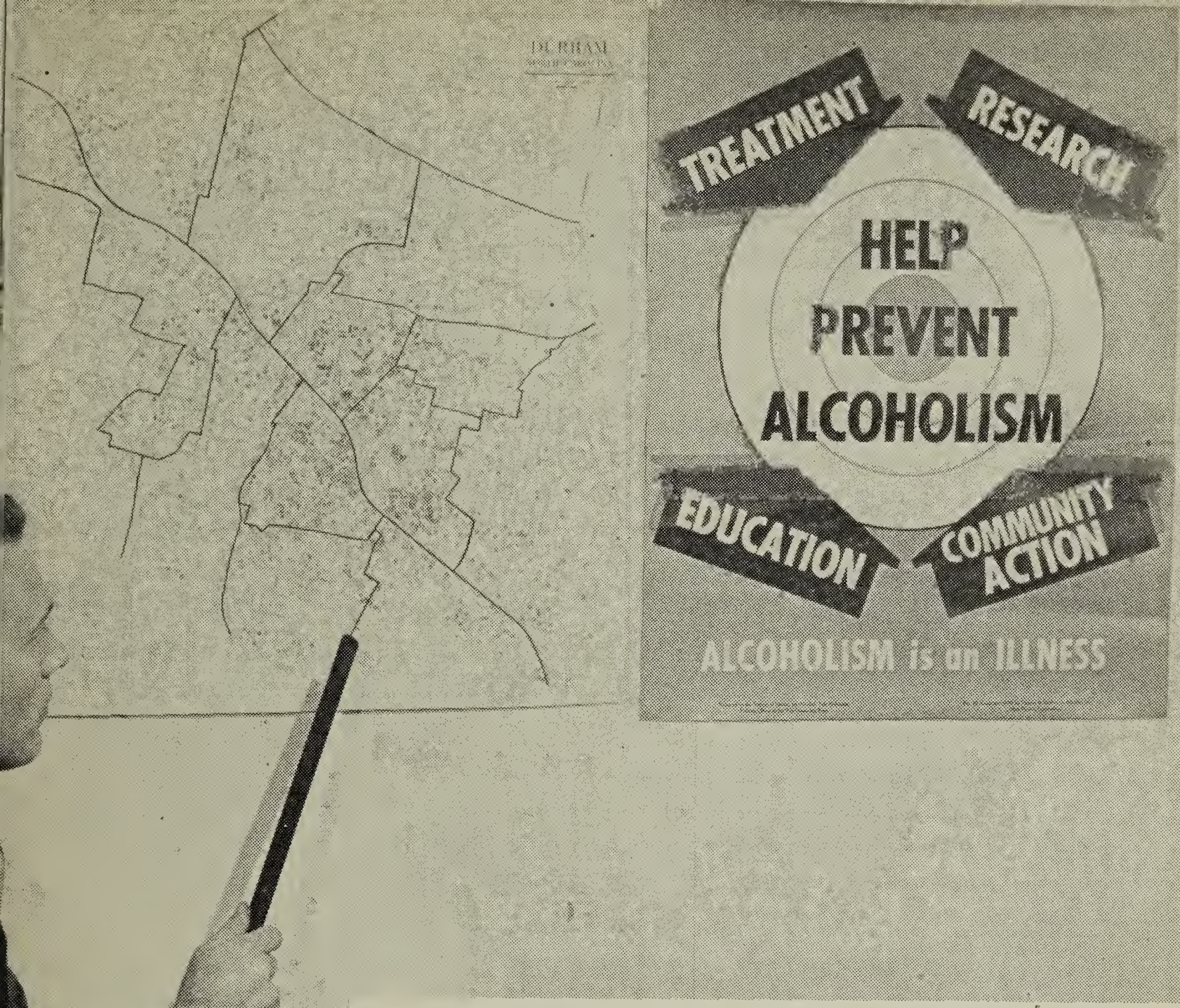
The average age of the convictees was 36 years old. One might postulate that this is the average age when one realizes that aspiration exceeds ability. For whites, the age is 41 and 31, for males and females, and Negroes, 39 and 34 respectively.



It follows that females, due to cultural emphasis placed upon youth and physical attractiveness, realize their aspiration level earlier than do men. However, further study is needed before such a hypothesis could be confidently offered.

According to race and sex, the white male leads in the average number of convictions (4.2), followed by Negro males (2.9), white females (2.7), and finally Negro females (2.4). A Chicago study by Faris and Dunham placed much of the blame for alcoholism on the breaking down of neighborliness. In Durham there appears much more cohesion between Negroes than among whites. Possibly this explains greater incidence of convictions among the Durham whites.

Spreading outward from the corner of Pine and Main Streets,



Robert Pace surveys a city map of Durham where he recently made an extensive study of public drunkenness for the ARP. He found nearly 11,000 convictions in Durham County between 1947 and 1950, enough in terms of human bodies laid end to end to stretch 12 miles, or almost from Durham to Chapel Hill.

the greater number of Durham convictees appear just outside of the commercial-industrial area, then recede to the outer rim of the city. A circle drawn from Pine and Main with a half mile radius would include the greater portion of all convictees.

As a general rule, the convictees live in comparatively concentrated areas. Type of housing provides a good, but not final index to location of convictees. The greater portion of white convictees are found in declining residential and low grade apartment areas. Here the possibility of being taken to task for a social behavior is at a minimum.

Negro convictees are concentrated into comparatively smaller areas

than whites, due to the narrow defines of colored residences. An apparent Negro ghetto is found south of Pettigrew Street, between Pine and Fayetteville Streets. Here housing conditions reach a low with an inverse ratio of convictions.

Besides housing, certain other social indices are found closely related to occurrence of convictees. High density of population, low occupational standings, birth rates, death rates, family services, old age assistance, aid to dependent children, blind assistance and other public welfare services exist hand-in-hand with numbers of convictees. Responsibilities are not being shouldered by the responsible members of the family.

An attempt was made to interview the convictees, the family or intimate friends in 75 per cent of all cases of 5 or more convictions. Out of a total 175 convictees, 52 interviews were completed. Approximately 60 per cent of those interviewed were whites who averaged 12 convictions apiece and 40 years of age. Negroes averaged 9 convictions apiece and 38 years of age.

Nineteen per cent of the interviewed were single, 50 per cent married and 31 per cent divorced or separated. Notable was the fact that whites were considerably more stable in their marriage. A greater percentage of Negroes was divorced, separated and single.

Reasons For Drinking Cover Wide Range

In education the whites ranked highest as might be expected. However, Negroes belonged to the church in greater proportions. (38.7%-61.9%) Only 5 convictees had any sort of hobby, yet most liked the jobs they held. Jobs for the most part were unskilled or semi-skilled.

Reasons for drinking alcohol ranged from, "it's the pure devil in him", to "it begins with a social drink, then becomes a habit and a problem." The respondents giving the more rational answers often expressed a desire to discuss reasons for drinking, rather than give a single dogmatic answer.

Public drunks, particularily the multiple convictees are maladjusted. They are not prepared for the role thrust upon them by a demanding, and not too consistent society. They attempt to hide their inadequacies by indulging in alcohol. For this they are condemned and punished. However, this doesn't reduce the true alcoholic's problem, nor the public's problem. Neither the public nor business and industry can afford to ignore this problem.

***Mr. Pace's survey was conducted under the auspices of The Institute For Research In Social Science at Chapel Hill through which INVENTORY frequently contracts such research services.*

– – As Much As He Needs It

"What can I do? Where can I get help? My husband needs help. If only he would want it as much as he needs it. Can you advise me?"

These questions of a North Carolina wife and mother are both typical and unique—typical in their urgency, unique in their insight.

In all probability, this wife of a problem drinker knew well the urgency of her pleas, but little realized the depth of her statement, "If only he would want help as much as he needs it."

And yet, probably better than anyone else in her own way, she does know the full, bitter truth of all she asks and says. Her major problem is getting her husband to want help "as much as he needs it." Experienced doctors and counselors in the field of alcoholism readily agree the help she seeks for him and the help he seeks for himself must come from outside of the family.

Such help can come from the family doctor, the minister, the trained case worker, Alcoholics Anonymous, and can carry weight when it is firm, frank, kind, and sympathetically objective. Usually, quite naturally the alcoholic's family and friends are so close to his problems and mistakes, so mixed up in their attitudes toward him that they cannot offer much effective help.

They can, however, "soften" him for his personal recognition of need by accepting and treating him like a sick person. They can avoid begging, appealing, threatening, and nagging. It's easy to dramatize, but it doesn't work. Patience means much more.

There Is Help—And Two Conditions

In further effort, they can discuss his drinking when he wants to look at it as a problem—not necessarily admit it right then—but just look at it. Wishes can then be made clear, and logical reasons given for each wish. But wishing alone won't make it so. The minister offers spiritual counsel. The doctor prescribes physical and mental inventory. Alcoholics Anonymous guarantees complete understanding and guidance born of bitter experience.

There is help for the North Carolina wife and her sick husband. And there are two conditions: she must be willing to let him face alone some of the natural consequences of his drinking; through that freedom, he must come to want help more than he wants anything else on earth.

It takes more than resolution to meet those conditions. From the wife, it requires an honest study of her part in the illness. From the husband, it demands a fearless inventory of all self-centered habits, emotions, attitudes, moods, and misconceptions that have caused much of the anxiety and instability.

Sometimes it takes the "psycho" ward of a county hospital to stir a man, in other cases the early morning dampness of a jail cell, or the gaunt faces of three hungry children telling daddy goodbye before they leave for school. But before he can gain any good out of any treatment anywhere through any method, the alcoholic sufferer must crave the treatment. As at the Butner ARP Treatment Center, treatment is voluntary, desire for it is compulsory.

From the ARP Family Manual on Alcoholism

UNIQUE IN THE NATION

Rowan County Blazes Educational Trail Toward Alcoholic Problems

By Peter P. Cooper, Director
Rowan County ABC Department of Education

On July 30, 1949, the qualified voters of Rowan County approved the establishment of an Alcoholic Beverage Control System. The law providing for the distribution of profits derived from the sale of alcoholic beverages in Rowan County also provided that "Before any profit shall be distributed as provided above, ten per cent (10%) of the profits shall be set aside for use for law enforcement purposes as provided by the general law *and for education as to the harmful results from abuses of alcohol . . .*"

The Rowan ABC Board, headed by Judge J. Allan Dunn, realized that in order to tackle the various problems related to the use of alcohol, a community must have, first, effective control of alcoholic beverages and rigid law enforcement; second, comprehensive and realistic education of the public—young and old; and third, adequate aid and treatment to be made available to existing problem drinkers.

A Basic, Realistic Approach

The Rowan ABC Board, having established effective control of alcoholic beverages and rigid law enforcement, then acted to provide the community with the second basic requirement for a realistic approach toward solving beverage alcohol problems—comprehensive education.

In June, 1950, the Rowan ABC Board moved to put that portion of the ABC Law pertaining to education into practice by appointing a full-time Director of Education and assigning him the task of exploring the field and setting up a meaningful program.

Due to the fact that there was not precedent for such a move in this nation, the Director was forced to begin almost from scratch. Seven months of wide and intensive research into available works on alcohol problems at UNC, Duke, Catawba, and Yale, in addition to considerable field research, resulted in a 15,000 word report to the ABC Board setting forth a proposed program of education and information on alcohol problems for Rowan County.

This proposed program was reviewed by over fifty different persons

in all walks of life. After suggestions and criticisms were incorporated, the program was approved by the ABC Board and Advisory Board in February, 1951. The approved program was not a rigid plan but actually a guide to action, subject to improvement and revision.

The ABC Department of Education is divided into three closely integrated departments—Library and Research, General Education, and Information and Guidance for problem drinkers.

A library of several hundred books, pamphlets, articles, records and films dealing with alcohol problems has been established and made available to the general public. Research on specific projects and problems is conducted as a public service. Information and education materials are prepared to fill particular needs.

Education on alcohol problems is designed to reach as much of the total general public as possible. Facts on alcoholism and other problems related to the use of alcohol are being made available to teachers, students, ministers, civic leaders, the general public, industry, and professional persons.

Impressive Growth Of A Vital Service

Already, many books have been placed in the public and school libraries; carefully prepared leaflets and posters aimed at alcoholism have been placed in the Rowan ABC Stores; a series of educational newspaper articles will begin soon; radio programs are planned for this fall; and a teacher training program, and subject integrated courses on alcohol problems will be offered to Salisbury and Rowan County Schools.

This past summer, two Rowan school teachers were sent to the Yale Summer School of Alcohol Studies on ABC Department of Education scholarships.. Next year, others will be sent.

The information and guidance service is an attempt on the part of the ABC Department of Education to provide some aid to existing problem-drinkers under the present Rowan ABC Law. The ABC Department of Education serves as a referral center—a go-between, between the Alcoholic and existing treatment facilities. Already, alcoholics have been referred to the Butner Alcoholic Rehabilitation Center, A.A., private clinics, and psychiatrists.

In order not to turn aside unaided the few alcoholics who cannot or will not take advantage of the above-mentioned treatment facilities, the ABC Department of Education also provides a form

Alcohol educator, Peter Cooper, often directs Rowan County sufferers to the Butner ARC for further help. Here he escorts a new patient into the Center.

VARIETY OF SERVICE

of re-education which is designed to help the alcoholic understand himself and alcoholism.

Of all alcoholics coming to the ABC Department of Education, an encouraging number of recoveries have been realized.

In addition, information on alcoholism and treatment of acute alcohol intoxication and alcoholism has been made available to local members of the medical profession.

The Rowan County ABC Department of Education cooperates at all times with Alcoholics Anonymous, the N. C. Alcoholic Rehabilitation Program, and other state and community programs dealing with alcohol problems. Also, the Department cooperates fully with local welfare, court, and public health agencies.

It is felt that such cooperation between all persons devoting their efforts to such problems is absolutely necessary in order to profit by experience and to prevent duplication of effort.

The Rowan ABC Department of Education does not serve as a spokesman for, or a promoter of, the ABC system or any other system.

Its sole purpose is to do everything it can in Rowan

County, through the medium of education and information, to solve existing problems related to the use of alcohol and to prevent future ones.

The specific objectives of the educational program are:

1. The unbiased presentation of scientific facts concerning the use and effect of alcohol on the individual and society.
2. The unbiased presentation of scientific facts concerning sound mental health as related to alcohol problems.
3. The encouragement of sane, constructive attitudes toward the problems of alcohol, and the elimination of prejudice and misconceptions which obscure the facts.
4. The recognition of alcoholism as a major social and health problem susceptible to prevention and treatment.
5. The development of a sense of responsibility for one's own welfare and that of others in the use of alcohol.

This ABC Education program is not part of a campaign or "crusade." It is a long-range effort and results will naturally appear slowly.

This very brief description of the only department of education of its kind in the United States is presented in an attempt to inform interested persons of what one community, operating on a small budget, is doing about alcohol problems and what other communities can do.

A Natural Link

To many people mental health is a vague abstraction, and facilities for dealing with it are either little known or considered a foreign project in a "far off institution." Actually it is inseparable from the basic realities of life: happiness, housing, enjoyment, schooling, satisfaction, food, recreation, job, peace of mind, etc.

Because of current emergencies and overnight changes, most of us are subjected to increased emotional strains. According to the North Carolina Mental Hygiene Society, "To meet these conditions, we must strengthen our emotional defenses through stronger community health programs." Veterans in the field of alcoholism now recognize the link between mental hygiene and the emotional needs of the alcoholic.

SELF-EXPRESSION THROUGH THE SOIL . . .

Physical And Emotional Health Often Found Through Gardening

By ORIN R. YOST, M.D,
Orangeburg, S. C.

Although this study of the therapeutic value of gardening does not mention alcoholism, emotional health sorely needed by most problem drinkers is treated here in a way highly applicable to the alcoholic. —*The Editor*

Gardening, if we may believe Genesis, is the oldest of occupations, and among all the recreational activities and hobbies indulged in by human beings, gardening is the best suited to all ages. Gardening, indeed all nature study, offers satisfactions for which none is too old, few too young.

Children of all ages take a loving interest in flowers, even babies being attracted by their colors; and many of the world's most enthusiastic gardeners have passed their "three-score years and ten." It can be said with truth that gardening is no respecter of age, race, creed or profession, for all the world loves a beautiful garden, be it composed of flowers, fruits, vegetables, vines or trees.

Health-Giving Values Of Gardening

Today, as we consider the motives of the many millions of our people engaged in this fascinating pursuit, it will be our purpose to stress, in particular, the health-giving or therapeutic value of horticulture. Incidentally, Richardson Wright, one of our well-known writers on the subject, has recently given to this activity the appropriate name "hortotherapy," the first part of the term being taken from the Latin word meaning "garden." Hence, "hortotherapy" means the curative treatment of human ills by gardening.

"Why," we ask, "does one indulge in gardening?" In reply, it might be noted that some people develop vegetable gardens in order to reduce the high cost of living, as they use the fruits and vegetables for household consumption. Sometimes whole communities and districts cultivate gardens in order to feed the hungry both at home and abroad. In support of these motives, let us recall the meaningful, successful programs, of the Victory Gardens during the war era and the Freedom Gardens of the post-war era.

Decline Of Nutritional Diseases

The latter program, as a health project, commends itself without reservation. When food in the war-ravaged areas of Europe and Asia was practically unobtainable, every report from those countries provided data on the need for food abroad. Our own South, with its practical disappearance of pellagra, and greatly decreased incidence of other nutritional diseases, also supplements this evidence.

Other people, it should be noted, indulge in gardening for fun, for play, or diversion, for gardening is a pleasant venture, and a delightful, profitable

pastime. Gardening, though never easy, offers a challenge to many who realize that a triumph over odds helps to build confidence, assurance and independence. A garden is unquestionably an opportunity for self-expression by the work of one's own hands and by nurturing living things.

Other people begin to cultivate garden plots, because their love for flowers develops into a desire to sow the seed, to grow them, and to produce cuttings. Gradually, the interest becomes a fascination, and almost before the horticulturist realizes it, he has become deeply absorbed in gardening.

Today, educational leaders are recognizing the value of gardening and, in some institutions, are encouraging children to take up this pursuit. Educators realize that, as old as gardening is, it is still in its infancy in the school room. As fundamental as it appears to be, it is still a greater riddle than history, mathematics or geography. Indeed, the chemist, botanist or philosopher can furnish no explanation of the behavior of the seed, the opening of the blossom, the call of the cricket, or the feel of the soil.

In Better Tune With The Universe

Yet all these mysteries are daily helping him in self-reliance, to combat juvenile delinquency; to develop appreciation of the beautiful, simple and worthwhile things in life. All boys and girls should be afforded, through gardening, the opportunity of understanding and appreciating the immediate world of nature that they might keep in better tune with the universe. Aside from these advantages of gardening for children, there is the important value of building healthier minds in healthier bodies.

Of course, there are many who, like the members of this organization, enter the pursuit of horticulture for the purpose of beautifying their homes and churches, or for becoming more expert in flower arrangement or acquiring new scientific methods for improving their efforts at horticulture, as well as for staging flower shows.

Therapeutic Value To The Sick

Other than the motives for gardening mentioned thus far, is the all-important motive of healing. Physicians and sociologists, in particular, have within recent years stressed its therapeutic value to the handicapped and the sick, especially those suffering from emotional and nervous disease. The crippled, the blind, and especially the elderly folks, who are unable to indulge in golfing, swimming, and other recreations, find that gardening is within the range of their physical powers.

The story is told that a prominent New York Supreme Court judge who was sorely wounded in the First World War was brought home from the hospital, still unable to walk. It was Spring. Always an enthusiastic gardener, he felt that if only he could plant some seed, he could get well much faster. So each day he was carried out to the garden and was set on the ground.

With great effort he managed to hunch himself along. After a few weeks of this, when weeds began appearing he found he could locomote on his knees. By midsummer he was walking and working all over the garden. It was a slow cure for the restoration of wounded leg muscles, but the desire to garden was the beginning of it. Fortunately, he had the desire.

"UNFOLDING OF NEW DELIGHTS"

Along the lower tier of New York, the story is still told of the brusque but eminently sane country doctor called in by a patient who was suffering from the ills attendant on having too much money. After his examination he said he would return the next morning with the medicine. He appeared bearing a spade, a rake, a hoe and two packages of seed and he prescribed a row of corn and a row of zinnias. It was not, however, his general prescription. Were gardening declared a cure-all, our hardware stores and seedsmen could scarcely handle the business.

Real doctors have always been "menders of distressed lives," and garden making has always been a favorite prescription for the pacification of man's inner conflicts. There seems to be a healing influence in every small plot of earth. There energy for the body germinates; there grief is stilled; and there irritation and fatigue vanish. Patients who indulge in horticulture enthusistically say: "I sleep better;" "I eat better;" "I actually am rested by the work."

"The Mere Spading Of A Plot"

It is to be remembered that gardeners are rewarded with the health-giving balm of sunlight and fresh air, as well as the benefits of physical exercise and the satisfaction of creative achievement. It has been observed that as a man works in his garden his tensions leave off. Gardening also affords stimulation of the mind, for as the patient merely watches things grow, he experiences a sensation of usefulness in production. The mere spading of a plot seems to banish worry.

Gardening clears the mind of many a cloud and rids the body of many an ill. Few things there are that can restore man's faith more effectively than witnessing a plant bursting into beautiful flower, or a once-cold, dead-looking bulb being transformed into a brilliant blossom. Whether the garden be only a few potted flowers gracing the window sill, or an extensive area devoted to truck, it will furnish a therapeutic value by its constant unfolding of new delights.

The general glad testimony is that troubles melt away in the serenity of a garden; its peacefulness and restfulness fit us for facing the trials of life and solving its problems, all of which must increase the length as well as the happiness of our days. It is, therefore, small wonder that in their rehabilitation programs for disabled veterans, the possibilities of gardening as a therapy have been widely explored.

Many tired desk workers and residents of overcrowded cities are likewise deriving health and happiness from horticulture. Especially do the men and women who engage in physical labor in large plants, such as the Ford Motor Company and the Firestone Rubber Company, find untold benefits as they cultivate flowers and vegetables on company-owned land or on their own property. Hundreds of executives and personnel directors report less absenteeism, better employer-employee relationships, much of which they ascribe to such horticultural projects.

What with improved fertilization, more scientific methods of cultivation, and ingeniously modified tools, many blind people today are finding acceptable outlets, diversion, profitable living and an extra incentive as they indulge in developing vegetable and flower gardens. For this group, garden-

ing is proving an especially desirable activity because it furnishes to the sightless an open air activity well suited to their other highly-trained senses. Many books on gardening are now being produced in Braille.

My own experience while employed as Reconstruction Officer in two Veterans Administration projects furnishes ample proof that gardening is highly beneficial as a therapy for distraught emotions. In one instance where land available at an abandoned camp site proved ample, psychotic and neurotic patients were assigned to such occupational therapies as planting and dressing vineyards, growing grain crops on the government farms and cultivating flower gardens. Trained occupational therapists, physiotherapists and attendants were always in charge of the patients who worked in groups of ten. The patients, provided with suitable clothing, were thus able to spend a great deal of time out of doors.

Pride In Gardening Easily Developed

In a similar set-up in one of the Eastern states, special emphasis was placed upon flower gardening which proved so fascinating to many of the patients that, after their discharge, they developed similar projects at their homes and continue to pursue this activity even at the present time. These patients, from all walks of life and few of whom had previously evidenced any interest in gardening, found pleasure and improvement in health of body and mind in the growing of flowers. In hundreds of cases of bed-wetting, development of interest in flowers brought such improvement as to effect a fifty per cent reduction.

The great majority of the patients given this form of therapy took great pride in exhibiting their blossoms within the sanitarium.

Also in a private mental institution I have noted marked improvement among patients who "dug and delved" among their flowers. At one of the well-ordered mental institutions in the North, I recall a very successful arrangement by which the patients, even during the winter months, spent most of their time in their gardens, some of them even developing artificial garden plots.

One Of The Purest Of Human Pleasures

With the approach of hot weather, patients would also remove their plotted flowers from the green-house and place them in the ground. On hand at this institution was a trained florist who guided and often lectured to the patients about their gardening projects. It is hardly necessary to say the interest shown by these patients and the rewarding benefits to them proved beyond all doubt the efficacy of hortotherapy.

That wise man, nearest perhaps of all to having been a universal genius, Francis Bacon, once said: "God Almighty first planted a garden; and indeed, it is the purest of human pleasures." The truth of this statement is not difficult for anyone to understand, for no one can deny that, "more grows in a garden than the gardener has sown."

Yes, the harvest of flowers, fruit and vegetables, when compared with the great health-giving values, may well be the least of the rich dividends a garden plot will pay.

Constructive Conclusions

In an age of factions and discord, two members of the alcoholic rehabilitation team are working more harmoniously than ever before in restoring the sick alcoholic. INVENTORY salutes the doctor and the minister and thanks them for their united efforts.

Religion and *Medicine* are in what some people like to call "surprising agreement" over the diagnosis of alcoholism and the suggested steps toward restoration for the alcoholic. To many quietly efficient workers in the field, the agreement isn't a surprise at all.

In an effective pamphlet titled *A.A.*, published by the Alcoholic Foundation in New York City, the comparative views are given in these five steps:

MEDICINE SAYS	RELIGION SAYS
1. The alcoholic needs a personality change.	1. The alcoholic needs a change of heart, a spiritual awakening.
2. The patient ought to be analyzed and should make a full and honest mental catharsis.	2. The alcoholic should make examination of the "conscience" and a confession—or a moral inventory and a frank discussion.
3. Serious "personality defects" must be cured through accurate self knowledge and realistic readjustment to life.	3. Character defects (sins) can be eliminated by acquiring more honesty, humility, unselfishness, tolerance, generosity, love, etc.
4. The alcoholic neurotic retreats from life, is a picture of anxiety and abnormal self concern, he withdraws from the "herd."	4. The alcoholic's basic trouble is self-centeredness. Filled with fear and self-seeking, he has forgotten the "Brotherhood of man."
5. The alcoholic must find "a new compelling interest in life," must "get back into the herd." Should find an interesting occupation, should join clubs, social activities, political parties or discover hobbies to take the place of alcohol.	5. The alcoholic should learn the "expulsive power of a new affection," love of serving man, of serving God. He must "lose his life to find it," he should join the church, and there find self-forgetfulness in service. For "faith without work is dead."

Emotional Needs Effectively Met By Occupational Therapy Program

Many Butner patients interested in combining brainwork with handwork are learning to answer some of their emotional needs through the Alcoholic Rehabilitation Center's occupational therapy program. Five afternoons a week, Monday through Friday, classes in leatherwork, metal tooling, simple carpentry, rug making and weaving, and other occupational lessons are available for patients desiring such relaxation.

Until recently, occupational therapists Doris Boyd and Elizabeth Alderman alternated in conducting the classes. They are now doing the same type of work on a special tour of England and the European Continent, and efforts are being made to fill their places at the ARC. The Center's attendants, E. C. Keith, J. W. Miller, W. T. Dupree, and E. J. Herring currently are supervising the O. T. program until three new therapists arrive.

More Than Workshop Activity Alone

The workshop is about 60 yards from the main building and is located in a long, rectangular structure that also houses the Center's projection room for showing daily films on personality development. Adequate facilities for summer ventilation and winter protection have been added to make the shop a year-round project. In front of the shop there is a large field ready for use as a softball diamond when it is cleared.

The O. T. program does not consist of workshop activity alone. One day a week is set aside for recreation, group games like volleyball, croquet, badminton, basketball, all of which the professional therapist likes to call recreational therapy. According to Butner's O. T. specialists, well-rounded therapy forms a combination of occupational, recreational, and social activities. Being essentially an O. T. program, however, most emphasis is placed on handicraft lessons.

Adequate Facilities For Building Skill

A newcomer with little workshop experience begins with simple leather projects and works up to handbags and intricate carving. From simple carpentry he can work up to the lathe and drill press. Recently installed foot looms and table looms for rug making and weaving offer considerable challenge to the patient desiring to take home a new rug or a sofa spread. Metal tooling is available along with equipment for covering boxes, jewel cases, ash trays and bowls.

Professional therapists define occupational therapy in terms of purpose. The Butner O. T. program has two aims—primarily to train the mind of the problem drinker to maintain the habits of normal activity through wholesome work, secondarily to help the patient find a hobby that appeals to him and that he can take home with him in successful restoration. By encouraging

purposeful work, social activity and recreation, this program helps build a well-rounded personality.

The O. T. service is not compulsory. It is set up only for those patients who want it, though the program is being designed to stimulate highest possible interest. Butner staffmen readily agree the patients themselves will be the biggest, best salesmen of the therapy by carrying their enthusiasm to others. A major problem is arousing hobby interests to which the patients can take their frayed emotional systems and general problem drinking conditions for needed diversion and relaxation.

Heavy Equipment Is Necessary

Although consideration is being given to a women's division at the Center, all of Butner's current patients are men, and heavy equipment is necessary for an effective O. T. program with men. Consequently the ARP has secured or is making every effort to secure the following types of equipment: a wood lathe and a drill press, band saws, jig saws, foot looms and table looms. Included also is general woodwork equipment consisting of hammers, saws, drills, planers, and special lumber.

Walnut, mahogany, and maple wood furnish the best lumber for finished handicraft work. Many of the patients are already making and paying cost

A Dual Purpose—To train the mind of the problem drinker toward normal activity through wholesome work; to help the patient find a hobby that appeals to him, that can be taken home and used when needed.

for the wood, leather, metal, or wool items they make and want to carry home. Human nature being what it is, when a patient makes an item for himself, he takes special pains with it. The ARP hopes future conditions will allow the Center to include the cost of one or two handicraft projects on the regular treatment bill.

At present if a patient can't buy what he makes, the Center holds the object for future exhibits and periodical sales. The ARC plans to display some of the better handicraft projects in a show case on the floor of the main lounge. Plans are also underway for garden landscaping to be included under either O. T. or a new recreational program planned for the near future.

The beginning was a simple one. The fellows took a few paint brushes, a bucket or so of cream enamel, and gave new life to the walls of the long-deserted shop. Work benches were added, floors were scrubbed and painted, and that was it until the looms and leather and strips of metal started arriving.

Reaching A Happy Medium

According to one Butner occupational therapist, "An O. T. shop is something you can spend all the money in the world on, or no money at all."

Butner's ARC is trying to reach a happy medium in the operation of its occupational therapy program. Center officials realize one O. T. must—the necessity of keeping the patients interested. They also realize the 28 days of treatment is just time enough to start the patient thinking, not only about himself but about a hobby and wholesome means of relaxation back home where it will really be needed.

FUTURE FARE

January's INVENTORY features these informative articles:

Education In Problems Of Alcoholism On The College Campus—An interesting study of the way a college teacher-counselor is interpreting the latest facts on alcoholism to the college classroom, written for INVENTORY by Professor Moses N. Delaney of Shaw University.

Ink Blots Lend A Hand—A revealing feature on the use of ink blots, formally called the Rorschach method, in testing, understanding, and treating sufferers of alcoholism. By Carl Ryerson, psychologist and Rorschach specialist at the Butner ARC.

Vitamins To The Rescue—The story of a typical week's menu at the Butner Alcoholic Rehabilitation Center and the part it plays in restoring many patients to nutritional well-being. By Miss Faye Williams, dietitian at the State Hospital, Butner.

Highlights From The Family Manual—A series of representative quotations from the ARP's new family manual, CORNERSTONES For Building A Better Understanding Of Alcoholism And For Securing Ethical Help For The Sufferer, recently published for distribution on request.

Bibliotherapy – The Use Of Reading As A Form Of Daily Psychotherapy

In his recent book on alcoholism, D. Anderson devotes a chapter to the history of lay therapy. He relates that one of the techniques used by Courtenay Baylor in treating neurotics (among them also alcoholics) was the prescription of definite daily reading.

Baylor was a layman who, in cooperation with doctors and clergymen in the Emmanuel Church in Boston in the early years of the century, successfully accomplished the rehabilitation of a number of alcoholics.

The principles of mental hygiene which Baylor formulated were elaborated and systematized by his leading pupil, Richard R. Peabody, who specialized in the treatment of alcoholics. Peabody likewise prescribed a program of reading for his clients, including a special set of daily notes which he provided.

"The Book"—Outstanding Example

Bibliotherapy—the use of reading as a form of psychotherapy—appears to be a common practice in the present-day treatment of alcoholics. An outstanding example of the informal employment of this technique is the reading of the book *Alcoholics Anonymous* by the members of A.A., among whom it is often referred to as "The Book."

O. W. Ritchie has reported that some alcoholics have been able to start their own rehabilitation solely through reading this book. Reading *The Grapevine,* official organ of Alcoholics Anonymous, as well as other A.A. literature, may also be a form of bibliotherapy for some A.A.'s.

Many medical therapists and members of allied professions working in therapeutic roles in clinics and hospitals serving alcoholics are undoubtedly using or attempting bibliotherapy at least as an adjunct in their therapeutic programs.

Technique Yet To Be Studied

This is evident, for example, from the numerous requests for literature "suitable for patients" received from these institutions and professions by the publications division of the Yale Center of Alcohol Studies.

In spite of the common prescription of reading, the professional literature contains no systematic reports on this procedure in the treatment of alcoholic patients. As yet there are no descriptions of the circumstances and forms of application of bibliotherapy, no analysis of its precise function or goals, no consideration of its applicability for different types of patients, no study of the suitability of materials, and no evaluation of its effects.

References

Anderson, D. The Other Side of the Bottle. (258 pp.) New York; Wyn; 1950.

Ritchie, O. W. A sociohistorical survey of Alcoholics Anonymous. Quart. J. stud. Alc. 9: 119-56, 1948.

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THREE STEPS FORWARD

The ARP has just completed a family manual on alcoholism. This guide is a 48-page, pocket-size booklet based upon the thesis that alcoholism is an illness of the human personality. It attempts to interpret that illness for the layman. It tries to help our citizens recognize the illness and do something about channeling the victims to proper treatment. It is presented especially as a family guide for state-wide distribution upon request.

Born of urgent need, the family manual takes the reader on a verbal journey of the following cornerstones to better understanding: What's Wrong With Joe; A Democratic Illness, At Least; Steps Toward An Insidious Illness; Some Teasing Temptations; There Is Help—Realistic, Experienced; Some Vital Whys—A Drama Of Reasons; Human Personality—A Prime Factor; He Should Desire Help As Much As He Needs It; Into The Clinic And A New Day; More Complete Treatment—Like That At Butner; Rehabilitation—A New Attitude; A New Approach To An Old Problem.

Administrators of North Carolina's general hospitals have a standing invitation from the ARP to observe the methods of setting up alcoholic facilities for temporary treatment of acute alcoholism. Traveling expenses and daily maintenance up to $10.00 are available to those administrators who desire to study the alcoholic facilities of four eastern hospitals that have pioneered in accepting problem drinkers—Episcopal and St. Luke's in Philadephia, and Knickerbocker and Townes in New York City.

Authorized by the N. C. Hospitals Board of Control, this offer is made to encourage and promote similar facilities for North Carolina. North Carolina's general hospitals are limited in their facilities and knowledge for temporary treatment of the problem drinker. The ARP believes hospital officials will be benefited by observing these pioneers and learning of the favorable reception their efforts have received.

A comprehensive brochure on the Butner ARC will be ready for state-wide distribution by the first of December. The 36-page verbal and pictorial view of the ARC will be mailed to any citizen upon written request. It features every phase of the Center's life and 28-day treatment. It emphasizes the Center's policy of voluntary admissions and attempts to portray convincingly the philosophy of treatment that is restoring scores of North Carolina sufferers.

It portrays Butner as a place of both restorative atmosphere and systematic treatment. It presents in words and pictures such phases of the treatment as the planned diets, the necessary medications, the stimulating group discussions, the films on personality development, the private consultations, the recreational facilities, the occupational therapy program, and the periods of personal meditation. It attempts to answer any questions a citizen might ask about the Center, from admission through treatment to discharge.

INVENTORY

If we are to understand the illness of alcoholism, we must take an inventory of what we know and don't know about beverage alcohol and human personality.

If we are to solve the problems of alcohol, we must identify ourselves with the illness of alcoholism. Major and *curable* maladies of today were considered incurable for years, until society chose to tackle them rather than avoid them.

Such identification takes teamwork. It takes the hospital and its physician, the church and its minister, Alcoholics Anonymous and its experience, the family and its newspaper, the public school and its teacher, the radio and its public forums, the health, welfare departments and their trained case workers.

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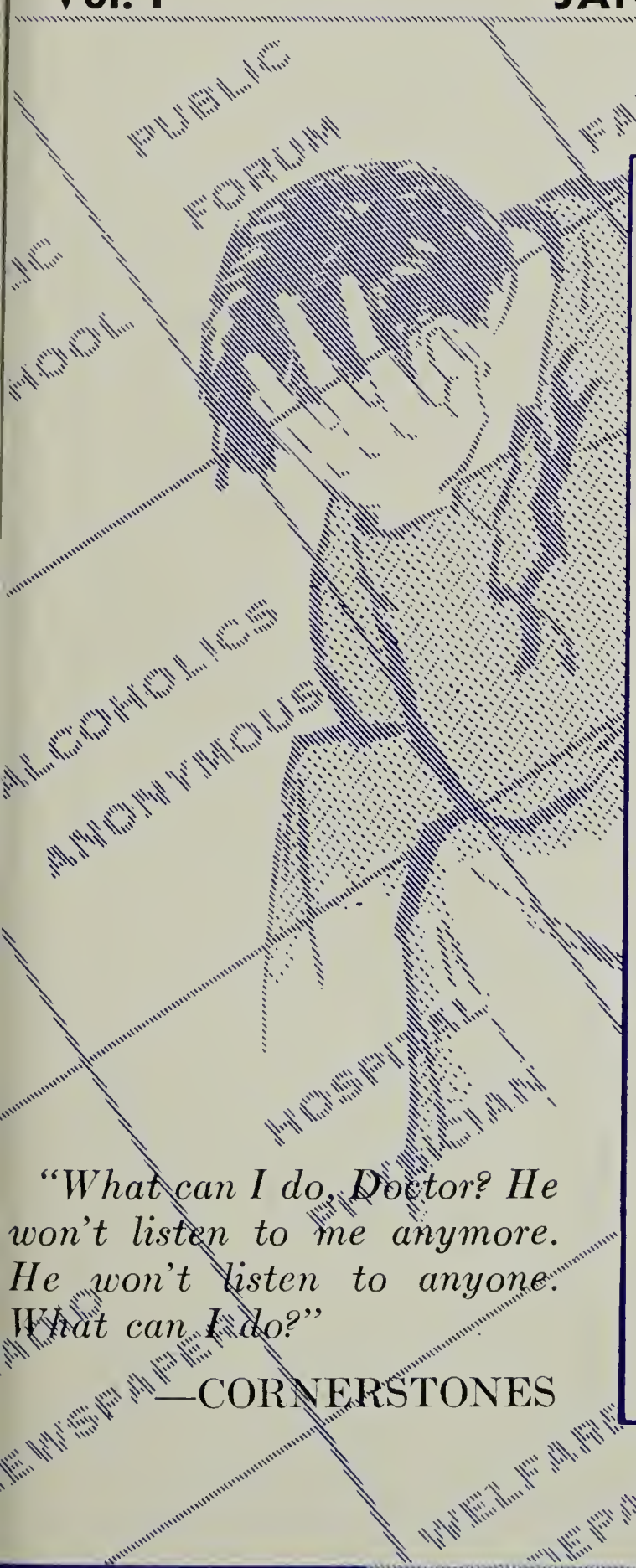
Miss Carrie L. Broughton, Librarian
State Library
Raleigh, N. C.

INVENTORY

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

Published By THE N. C. ALCOHOLIC REHABILITATION PROGRAM

Vol. I JANUARY, 1952 No. 5



"What can I do, Doctor? He won't listen to me anymore. He won't listen to anyone. What can I do?"

—CORNERSTONES

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TREATMENT REHABILITATION EDUCATION PREVENTION

INVENTORY
BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

VOL. 1 NO. 5
JANUARY, 1952
RALEIGH, N. C.

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LORANT FORIZS, M. D.....*Medical Director, ARP*

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C., UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

In Tribute

Following the first edition last May, this journal received a letter from Dr. H. O. Lineberger, then chairman of the North Carolina Hospitals Board of Control, the journal's governing body. The counsel expressed in that letter is INVENTORY'S best way of expressing grateful tribute for the life of Chairman Lineberger who died late Friday afternoon, December 7, 1951.

State and national dental leader and late chairman of the Board that governs the State's mental institutions, Dr. Lineberger gave the ARP this advice which is now the heart of the journal's editorial policy: "Let the public have the facts which should arouse valuable reaction. These reactions combined with INVENTORY'S information should crystalize into a definite program of valuable results."

PERSONAL IMPRESSIONS

According to many of the patients, a leading factor in the Butner treatment is the atmosphere which meets each new patient. First impressions are often strong ones, and the first impression a new patient receives of the Butner Alcoholic Rehabilitation Center is the handshake and the welcome of the attendant on duty. Chief attendant, E. C. Keith, and his associates have a way of putting the sufferer at ease, of assuring him Butner is different.

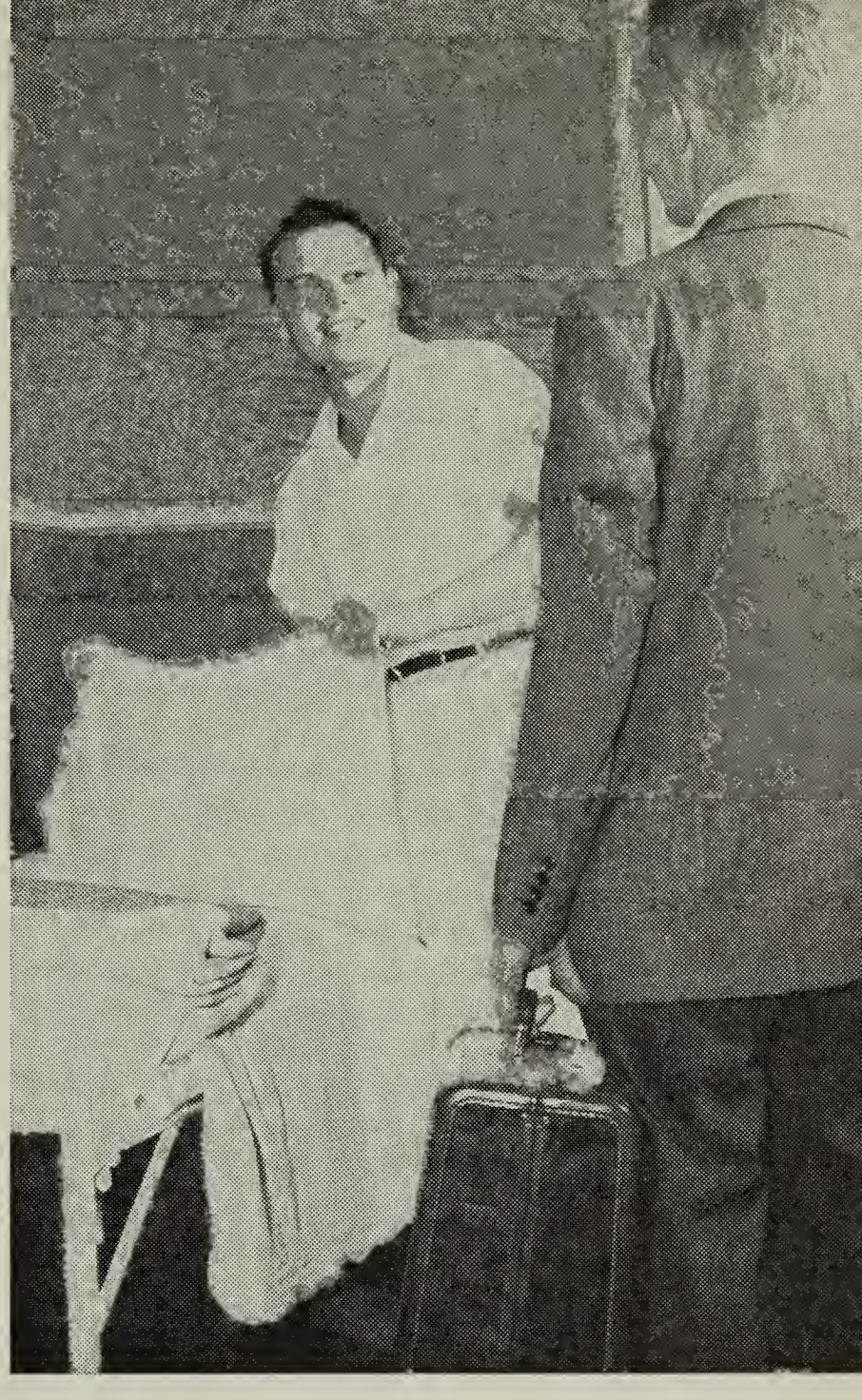
"The attendants? They're swell fellows—Keith, Miller, Herring, Hoyle—they're all swell guys who know how to help a fellow get back a little confidence he lost back home. This fellow Keith, chief attendant, is mighty likeable, always the same guy, cheerful, considerate, always friendly and regular."

The gray-haired patient spoke calmly between slow puffs on his cigarette. He was talking casually about his personal impressions of the Center to

which he had come voluntarily for help.

"I won't forget the way Keith greeted me that first day, how he smiled and introduced himself and helped me sign in. After he showed me to my room, I picked up my bag kinda self-conscious-like while he made up the bed and answered some questions I didn't have the nerve to ask the folks over at the administration building.

"You know, last July I ran across a copy of this INVENTORY journal you people put out—a number of folks in my county get copies—and I read the piece on Butner being an atmosphere or something like that. I kinda sneered at it at first—'specially where the fellow said Butner was different, no guards, no cells, no sorry food. Said something 'bout it being like daylight after a foggy night. I remember that. Said they greet you like a man, shake your hand, treat you decent, attendants, doctors and all.



"I really sneered. Down inside I figured it was another stunt to trick 'bums' into getting off the streets for a few weeks. Couldn't believe in this atmosphere claim, this getting your bearings business. Didn't add up, being a state institution. Never been done before, why start now? 'Course, this fall I got pretty bad off. Guess I was ready for help.

"Whatever they want to say good about Butner is right by me now. I wish everybody in North Carolina could know how decent and genuine they treat a 'drunk' like me. 'Course, I don't take much to that term 'drunk' anymore. I realize now I've been sick and I've got to help the doctor and God help me get well. And calling myself a 'drunk' and thinking myself one isn't gonna help.

"Folks here sure seem to mean it when they say, 'Joe, you've been sick, and you've come for help . . . we believe you can be helped, if you want that help.'

"Attitude like that helps you feel there's something worth living for. Helps your thinking improve to deal with problems you once drowned in alcohol . . . helps you take that inventory the doctor speaks of and get an open mind to learn the causes behind your drinking. Reckon I've said enough, with my word knowledge. Might add, Butner's a wonderful place for anybody who wants to try to tackle his alcoholic emotions."

The Butner ARC cordially receives any man who is sincerely trying to learn and conquer his alcoholic personality. INVENTORY believes that such a sufferer shall ultimately be given so long as he seeks, shall ultimately be answered so long as he asks.

SOME TECHNIQUES IN . . .

College Teacher Discusses Urgent Need For Education On Alcoholism

By Moses N. DeLaney, A.B., B.D., M.A.
Shaw University
Raleigh, N. C.

In modern times education has been offered as a panacea for nearly all the ills of society. Experience has shown that in many areas of social, political, moral and spiritual relations, education is a powerful weapon in helping to solve the problems of the world. Nevertheless, with all of our colleges, universities, churches and other social agencies, the mounting problems of alcoholism in our country still arouse great concern among numerous circles supporting human advancement.

As it is used here, the term, "alcoholism," includes those excessive habitual uses of beverage alcohol which create serious personal and social problems for the individual. The purpose of this study is to state briefly the need for education in problems of alcoholism on the college campus and to suggest some techniques in meeting this need.

No Simple Answer To The Problems

The need for education in problems of alcoholism arises immediately out of the prevalence of social drinking on the college campus today. A recent study of thirty-one North Carolina institutions showed that drinking is "the second ranking problem" on these campuses. However, in the nation as a whole, drinking has been adjudged "a major social problem" and alcoholism "the number four health problem."

Second, there is no simple answer in understanding and solving the problems of alcoholism. Careful research has shown that the social situations giving rise to alcoholism are deeply rooted in the patterns of human behavior. Hence, there is a need to understand the historic, cultural, psychological, physiological, emotional, moral and spiritual forces which influence human conduct.

Third, the complexity of the problems makes education necessary as a preventive measure. For example, modern psychology has thrown great light upon factors which make for emotional maturity and immaturity. It has shown that personality stability and insta-

bility may be traced to early childhood experiences which condition adult behavior. These childhood experiences, in turn, contribute to the development of alcoholism in the adult years. Consequently, an educational program based upon sound mental hygiene principles should begin with prospective parents and continue through the period of maturity of their children.

Fourth, there is a need for understanding those problems of alcoholism which cause further liability to society. These are evident in the sufferings of the family, the increase of certain types of crime while under the influence of alcoholic beverage, the hazards created on the highways, the loss of time and productivity to industry, and the disintegration of human personality.

Education Toward A New Attitude

Fifth, education helps society change its attitude toward those who have become sufferers from alcoholism. These individuals must be viewed as sick persons for whom there is rehabilitation if they are willing and ready to submit themselves to the treatment. Hence, it becomes possible for them to be restored to social usefulness and self-determination in a free society.

Finally, education in problems of alcoholism is necessary because most colleges are training grounds for public school teachers and other community leaders. Since every state in the Union has legal requirements for instructing youth on the effects of beverage alcohol, these teachers must be trained to meet this need. Several of the teachers attending the 1951 Yale University Summer School of Alcohol Studies indicated that the need is not being met satisfactorily. Thus, the college curriculum should help prepare our prospective and in-service teachers to meet this challenge.

"More Than The Chemistry Of Alcohol"

As INVENTORY effectively states, "We should provide our young people with more facts than just the physiological effects of alcohol upon the human body. We should show them the connection between addictive personalities, emotional health, and alcoholism. We should acquaint them with more than the symptom of alcoholism, which is alcohol itself.

"We should acquaint them with the causes of the illness which usually go deep into the addictive personality's relationship with himself and the world. We should clearly show them the difference between a sick personality and a healthy one and the paths to each

condition. Alcohol education is more than the chemistry of alcohol and its effects upon the human body. It is also a matter of mental hygiene knowledge and practice."

Methods Of Studying The Problems

All the means of the educative process can be used effectively in studying the problems of alcoholism. Chief among these are the following: The lecture; frequent visits to rehabilitation centers and open meetings of Alcoholics Anonymous; demonstrations of the effects of alcohol on lower animals and its observed effects on man; reading research; essays, editorials and research papers; the drama; the small discussion group; the socio-drama; and audio-visual aids. Through public health services, highly instructive films are available, like Emotional Health, Meeting Emotional Needs in Children, Feeling of Rejection, Over-dependency, Feeling of Hostility, Alcohol and the Human Body.

Active Participation More Rewarding

It is being found increasingly that those aids which bring the learner into active participation are more rewarding than those in which he is more or less a passive listener. To illustrate, currently, the Intercollegiate Association for Study of the Alcohol Problem, Columbus, Ohio, is sponsoring a short editorial contest for non-professional writers on the college campus. It is open, therefore, to all college students. A bibliography is supplied and the general theme of the contest is: "Can Education Solve the Problems of Alcoholism?" Seventeen thousand dollars will be awarded in prizes.

The college curriculum is a proper channel through which education on problems of alcoholism should be carried out. Some courses of study dealing exclusively with these problems may be set up. On the other hand, many of the existing courses of study are readily adapted to the treatment of the problems. Such courses are as follows: "Social Problems," "Personality Adjustment," "Social Pathology," "Personal and Mental Hygiene" and "Religion and Ethics."

The Enlarged Concept Of Alcoholism

Many of the private and church-supported colleges have a Department of Religion or a School of Religion, or both. These are designed especially for the training of Christian ministers, Christian educators and missionaries. It is vitally important that these leaders be given the enlarged concept of the problems of alcoholism. Our future

leaders must recognize alcoholism as a sickness. They must approach the alcoholic as a sick person and treat his condition as a health problem.

Courses in "Parish Ministry," "Parish Problems," "Pastoral Psychology and Counseling" and "Christian Social Problems" may be used to train Christian leaders in a philosophy and technique of dealing with these problems and, most especially, of counseling the long-neglected sufferer.

Social Approval And Disapproval

Student religious organizations are found on most college campuses, whether state, private or church-supported institutions. These include the Student Christian Association, the Y.W. and Y.M.C.A.'s, the Methodist Youth Fellowship, the Baptist Student Union, the Young People's Guild, the Westminster Fellowship and many others. Participation in these organizations is usually voluntary. The writer has observed enthusiastic interest and support of the organizations on numerous college campuses.

FUTURE FARE

In March, INVENTORY presents these interesting features:

Alcoholics Anonymous Life Behind Prison Walls—The story of the Alcoholics Anonymous Group in the Minnesota State Prison, a challenging epic of creation and rehabilitation, written exclusively for INVENTORY by Inmate No. 16999, editor of Pen Pointers, prison's lively AA journal.

The Minister Meets An Alcoholic—A general observation of alcoholism, featuring three case histories and six suggestions for the minister confronted by the problem in his own community, written for INVENTORY by Chaplain Harry Hubbard, Veterans Administration Hospital, Oteen, N. C.

What Can I Do?—The story of a Lenoir County teacher who didn't exactly find time on her hands, with a family and a daily classroom to look after, but who felt a strong desire to "serve in the field of alcoholic rehabilitation where I felt so much good could be done."

"Doc, You've Been Reading My Mail"—A vivid interpretation of Butner's four psychological tests and the various results that can often be used by both the patient and the doctor in understanding the causes of the sufferer's abnormal compulsion. By John Mendenhall, ARC Psychologist.

CHANNELS TOWARD PREVENTION

These organizations are rooted historically in support of temperance philosophy, emphasizing abstinence from alcoholic beverages. Through the ages, social approval and disapproval have been the most effective means of social control. Consequently, on the college campus, these organizations offer one key to control through Christian commitment.

Many colleges have an in-service training program for groups with various interests. Some of these are for professional leaders in different walks of life, such as the 4-H Club, the Boy Scouts, Camp-Fire Girls, public health service, public schools, the ministry and lay church leadership.

Preventive Education For Growing Youth

Each one of these forms a valuable channel through which the college may extend the educative process to larger segments of the population. To be sure, persons serving in these areas are in the rough-of-life situations in which personality is in its earliest stages of development. Consequently, their understanding of the problems involved and the need for preventive education will be of inestimable value to growing youth.

Thus, we see that education in the problems of alcoholism is a great need on the college campus, that persons who have been trained in this area give great promise of aiding in the prevention and control of this illness in modern society. It is up to each college to use every opportunity to meet the challenge of this pressing problem.

(Editor's note: Many of the suggestions included in this article are part of Shaw University's new plans for an educational program on alcoholism. In connection with these plans, Author DeLaney says, "I wish to express my deep gratitude to the North Carolina Alcoholic Rehabilitation Program for scholarship aid making it possible for me to attend the 1951 Yale University Summer School of Alcohol Studies. Our Shaw program on alcoholism is being based upon Yale's sound platform of scientific truth in all problems pointing to the alcoholic sufferer. We also plan to use INVENTORY and its effective blend of scientific facts and human sympathy.")

EVENTS TO COME

Two events are on the future agenda of alcoholic rehabilitation efforts in North Carolina. On May 23, 24 and 25, the 1952 North Carolina State Convention of Alcoholics Anonymous will be held in Raleigh. This convention will feature AA speakers from the State and nation.

The North Carolina Alcoholic Rehabilitation Program will sponsor a week of Summer Studies on Facts About Alcohol, June 9-14, on the campus of the University of North Carolina at Chapel Hill.

A HARD WON, NEW WAY OF LIFE

FOUND BY A NEW BERN AA

With the knowledge I have obtained from trying to live the AA program, I find that the principles rank first in importance, providing a foundation for my recovery. Since getting rid of my dying alcoholic personality and facing reality, it is my duty to develop the kind of personality which will enable me to deal and live with people.

I am not sober for sobriety's sake but for my own good. I find the Twelve Steps the heart of the program and I keep them in mind, going over each one carefully, to improve my conscious contact with the power from whom I draw my strength, inward peace, and the love I hold for my fellowman, in order that I might help others as I was helped. With the privilege I was given of using these divine opportunities, I must practice the AA principles in all my affairs to the best of my knowledge. My mental, physical, and spiritual conditions must be in harmony with the Twelve Steps. My personality will express how well I am living the program and sharing it.

"A Ladder, Stepping Me To Higher Ideals"

Growing up in sobriety, I need something more than the top surface, such as depth of a spiritual understanding and faith. I must remember that I am completely dependent upon God and the program for life and that the Twelve Steps are a ladder, stepping me to higher ideals. Desires are God's given forces of the personality and without them life would hold no principles. I must have enough inward desire to obtain higher principles to a successful, normal life. AA principles are guides to this success.

My new way of life in AA was hard won, and I must protect it at any cost. To do so, I must be constantly aware of my behavior before Mr. Public. For best action, I need a substantial harness consisting of humility, honesty, and sacrificial giving and I do not ask for the credit of the giving. My first common interest is sobriety—freedom from the bottle. The other things will develop if I continue to be guided by the Twelve Steps.

"Reserve Strength Is Highly Important"

Some stress the matter of attending church. That's the privilege of the individual. However, do not single out a specific day (Sunday) and place to demonstrate. To practice these principles in all my affairs, every day, is real Christianity in action on a 24-hour basis.

There are many activities that go to make up my daily living. I am often confronted with situations that tend to leave me bewildered and I have to call upon my reserve strength. And, believe me, reserve strength is highly important. I acquire it through prayer, faith, and attending meetings. Faith enables me to feel the presence of God and to realize that my life is no longer unmanageable. I cannot express the gratitude my happy heart would unfold, so I give thanks and credit to God by quietly helping my fellowman.

Surely, the person who honestly practices the AA principles in all his or her affairs is a religious, cosmic person.

(CHIPS, New Bern AA journal, features these views in its Christmas-New Year issue.)

"REACT TO THESE CARDS . . .

Patient's Personality Problems Often Studied Through Inkblots

By Carl Ryerson
Butner Psychologist

In 1847, a book describing the use of ink bolts was published in Germany. This book was the forerunner of the Rorschach test that is now widely used by psychiatrists and psychologists in gaining an understanding and an evaluation of the people who come to them for help in solving personal problems.

During the last half of the past century, psychology was beginning to break away from philosophical speculations about man. There was a new interest in attempting to understand him through experimental methods of a more systematic manner, approaching present day scientific thinking. In this same period in medicine the beginnings of present day psychiatry were developing.

Ten Inkblot Pictures Selected

A Swiss psychiatrist, Herman Rorschach, became interested in the inkblot test in 1911. Prior to this the main interest was in what a person made out of the blots, but Rorschach found that variations of formations and qualities in the blots a person took notice of were also significant. He found that different ways of seeing those variations reflected facets of the personality.

After ten years of experimentation with thousands of trial inkblots, a standard series of ten inkblot pictures was selected in 1921. This is the set of inkblots most widely used at the present time. Since 1921, there has been a large number of research studies done on the inkblot test, now called the Rorschach, improving the technique and greatly increasing its value as a means of understanding personalities.

The Rorschach Test indicates largely what kind of personality the patient has. From it, the psychologist often learns how the patient will handle new situations and how he probably has reacted in the past. The ways a person develops patterns that give him satisfaction or dissatisfaction in life may be revealed to the psychologist in evaluating reactions to the Rorschach inkblots.

"Put There By His Imagination"

The basic assumption in the evaluation of reactions to the blots is that in any situation a person by his behavior reveals his habits, attitudes and ways of adjustment. Since the "situation" in the Rorschach test is merely a series of inkblots without definite picture-like form, a particular person's reactions or "what he sees" in the blots is more or less put there by his imagination. Thus a glimpse into the workings of his personality may be gained. A picture of a person's assets and liabilities or the positive and negative ways he has made use of his physical, intellectual, and emotional potentialities may be seen.

This personality picture along with a social history, daily observation while at the Center plus the psychiatric evaluation form an understanding of the person. This understanding can be used by the doctor and the patient together to help the patient realize his personality problems. Also the potentialities hidden before by these problems may be pointed out in a helpful way.

Generally, the conditions in which the Rorschach is given are held to certain standards as much as possible. The test is given in a quiet, comfortable room with the relationship between the examiner and the subject quite informal. A preliminary explanation is given, to help the subject realize that the test is a routine examination.

At First, It May Seem Far-Fetched

In this it may be pointed out that the results will enable the doctor to have a better understanding of the patient and will be more able to help him. To practically everyone, the inkblots are brand new and the idea that any valuable information might be gained from what a person sees in them may seem far-fetched.

Reactions to the first explanation of the procedure, as well as reactions throughout the test, give indications of how a person might handle a situation with which he is unfamiliar. These reactions may vary all the way from ready acceptance and willingness to attempt to handle the situation with confidence to evasive excuses and signs of apprehension.

After the patient has been helped to feel at ease, more particular instructions concerning the test are given. In the instructions, the subject is left to react to these cards as freely as possible. Although there is no set statement of instructions, they generally run as follows:

"We Have Here A Set Of Cards"

"We have here a set of cards, each one having inkblots on it. Look at each card and tell me what you see or anything that might be represented. You may look at the card as long as you like, but tell me everything you see. When you are through looking at a card place it on the desk as an indication that you have finished and we will go on to the next one."

Then the testing itself begins. After the patient has seen all the cards, and his responses are recorded by the examiner, they are gone through again to clarify what was seen. That ends the test as far as the patient's part is concerned. The examiner's job now is to score the test, arriving at an understanding of the aspects of the patient's personality.

This is done by working out the interrelationship of numerous factors. For example, there are some responses given by almost everyone. Whether or not a particular patient sees all, or part, or none of these can give an indication of his awareness or sensitivity to conventional situations. His being in line or not with the average person's manner of approaching problems may be suggested.

Another important factor is the area of a blot in which a response is seen. From this, some indication can be gained as to whether or not a person thinks in comprehensive terms with well formulated, logical organization. There may be indications suggesting a person's tendency to think

in theoretical or abstract terms or, on the other hand, in terms of more practical, down-to-earth ideas.

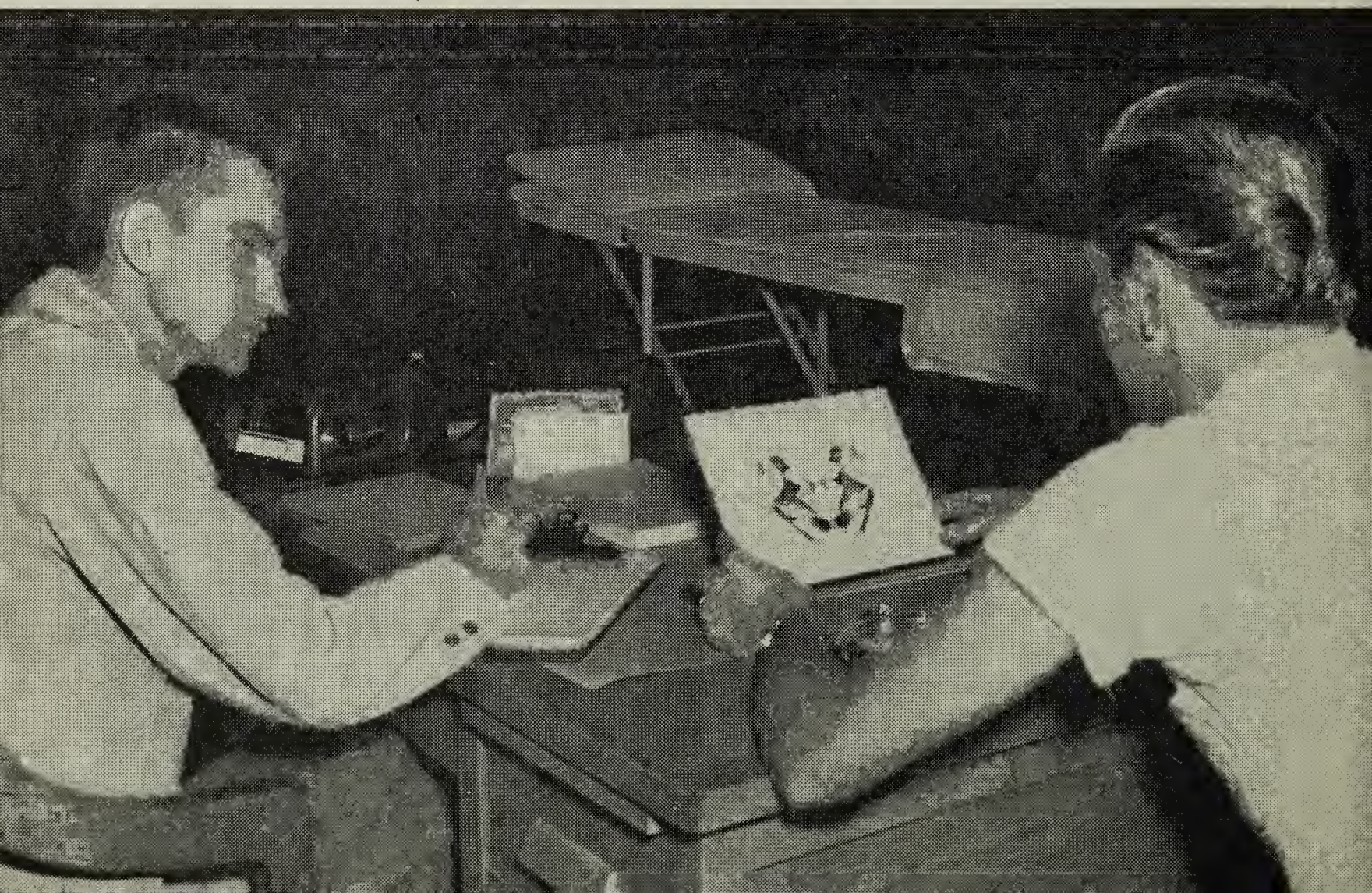
From the relationship between certain scores, an evaluation can be made of the patient's concept of himself, how he makes use of emotional and intellectual capacities. An indication can be found of a person's confidence in his own abilities or his tendency to be somewhat lacking in confidence and perhaps to allow emotional disturbances to interfere with his normally good judgment.

Insight Into Various Social Pressures

He may be functioning on a somewhat immature level because of some insecurity in his life situation that causes him to be fearful of asserting himself more maturely. Along this line, insights into the patient's relationships with his environment, family and social pressures may be seen.

No particular item in the scoring of the Rorschach is of much value in itself. It is only through a study of all the scores and their relative emphasis or lack of prominence can a more complete, balanced personality picture be gained. The conclusions are written as a report to aid the doctor in evaluating the patient's problems and assets for overcoming those problems.

"We have here a set of cards. Each one has inkblots on it. Look at each card and tell me what you see or anything that might be represented. You may look at the card as long as you like, but tell me everything you see. When you are through looking at a card, place it on the desk and we will go on to the next one"—A Butner psychologist records the patient's impressions of the Rorschach inkblots.



EMOTIONAL HEALTH IS BASIC

In another part of this issue, a member of the Salisbury Alcoholics Anonymous Group reveals an interesting personal conviction. Speaking strictly for himself, the Salisbury AA makes this observation:

"Unquestionably the alcoholic is emotionally maladjusted or sick. Emotionally he is diseased . . . if we say, therefore, that the compulsive drinker is 'emotionally sick,' then we are indisputably correct and no one may rightly take exception to the diagnosis."

These are the words of a man who has suffered from alcoholism and has recognized his own sickness as an emotional condition. Veterans in the field of alcoholism are daily recognizing the link between mental hygiene and the emotional needs of the alcoholic. Emotional stability and health are inseparable from good mental health. Mental health includes the basic realities of life: happiness, peace of mind, housing, enjoyment, schooling, satisfaction, food, recreation, job, contentment, etc.

INVENTORY recently received some vital facts from The National Association for Mental Health of New York City, listing some of the basic characteristics of people with good mental health. The link between these characteristics and emotional maturity so vital to the alcoholic is self-evident.

INVENTORY presents the following characteristics listed by The National Association as a fitting picture of an emotionally healthy person:

He feels comfortable about himself. He is not bowled over by his own emotions—by his fears, anger, love, jealousy, guilt or worries. He can take life's disappointments in his stride. He has a tolerant, easy-going attitude towards himself as well as others; he can laugh at himself. He neither underestimates nor over-estimates his abilities. He can accept his own shortcomings. He has self-respect. He feels able to deal with most situations that come his way. He gets satisfaction from the simple every-day pleasures.

He feels right about other people. He is able to give love and to consider the interests of others. He has personal relationships that are satisfying and lasting. He expects to like and trust others, and takes it for granted that others will like and trust him. He respects the many differences he finds in people. He does not push people around, nor does he allow himself to be pushed around. He can feel he is part of a group. He feels a sense of responsibility to his neighbors and fellow men.

He is able to meet the demands of life. He does something about his problems as they arise. He accepts his responsibilities. He shapes his environment whenever possible; he adjusts to it whenever necessary. He plans ahead but does not fear the future. He welcomes new experiences and new ideas. He makes use of his natural capacities. He sets realistic goals for himself. He is able to think for himself and make his own decisions. He puts his best effort into what he does, and gets satisfaction out of doing it.

Progressive Industries Adopt New Views Toward Alcoholic Employees

By Wayne W. Womer
Executive Secretary
Virginia Church Temperance Council, Inc., Richmond
Assistant to the Director
Yale University Summer School of Alcohol Studies

Scientific authorities estimate that there are four million or more alcoholics in this country. This figure is most impressive. But what is an alcoholic? Some scientists have defined alcoholism as a "physicial, mental and spiritual disorder of living."

A recent issue of the Virginia Health Bulletin states that "alcoholism is a chronic and progressive illness caused by excessive and uncontrolled drinking of alcoholic beverages." In Virginia during 1944 there were 27,072 people committed to jail for drunkenness, drunk and disorderly, and drunk driving.

"To More Than Ten Billion Per Year"

By 1948, this number had increased to 53,014 and the present figures are at this level. This is worth noting. Seriously considered estimates of the annual cost of this condition run to more than 10 billion dollars per year.

The cost in terms of lost manpower, suffering of alcoholics and their families, and deterioration of community and moral strength are not susceptible to dollars and cents computation. Whether we wish to be interested or not, the loss is carried by all of us. The striking fact is that much of this loss could be stopped with the knowledge and techniques now available.

"Also A Scrap-Pile Of Human Waste"

America has been a land of waste. Outside our towns and cities are great piles of waste materials. We have also a scrap-pile of human waste. Today, however, we realize that we cannot waste men or materials.

Less than five years ago the subject of "Alcoholism" appeared for the first time on the program of the annual meeting of the American Association of Industrial Physicians and Surgeons. Many members were surprised by its appearance. However, there has been a remarkable change.

OLD SLOGAN IS NO SOLUTION

Industry is becoming concerned about the problem of alcoholism. Dr. John L. Norris, of the Eastman Kodak Medical Department, writes, "A Company that says it does not have any problem with alcoholism among its employees does not know what it is talking about." A survey by the Yale Center of Alcohol Studies reveals that in 1943 over 1,370,000 inebriates were employed in industrial pursuits.

These men lost on an average of 22 working days yearly because of acute intoxication. Alcoholics have a lower capacity for recuperation from disease; hence they are absent due to sickness on an average of two days more than their normal co-workers.

In the survey year, alcoholism was directly responsible for the loss of 32,400,000 working days. That there were also 1500 fatal accidents more than doubled the normal rate. These men were also responsible for 390,000 work injuries.

Evidence Of A Changing Attitude

Industry is beginning to sense that the old slogan, "The drunk is the last man hired and the first man fired," is no solution to the problem. The evidence of this change may be seen in a variety of events: formal public statements from companies like Allis-Chalmers, Consolidated Edison, Du Pont, Eastman Kodak; the appearance of many articles in Trade and Industrial Journals like *Chrysler Motors Magazine, Office, Printer's Ink, Ethyl News, Sales Management.*

Further evidence includes a regular committee on alcoholism in the American Association of Industrial Physicians and Surgeons; a six months' information campaign on alcoholism undertaken jointly in 1950 by six companies in Wisconsin; the mounting number of inquiries from business and industry reaching Alcoholics Anonymous groups, the Center of Alcoholic Studies at Yale, the State Commissions on Alcoholism; the increasing number of institutions on Alcoholism in industry. That a change has taken place is readily apparent.

A Chance Should Be Given To Him

A number of industrial concerns are now operating on the basic premise that an employee should not be discharged because he is an alcoholic, but if he wants to stop, the opportunity should be extended to him. The Allis-Chalmers Manufacturing Company, one of America's largest corporations, has recognized that the out-of-control drinker is a problem in the shop and office.

As the company grew in size the problem grew in size. A com-

mittee for the study of alcoholism was brought into being to find out first how extensive the problem was within the corporation. It was found about ten per cent of the employees who were discipline cases were problem drinkers. They decided to do something about it.

The plan for an alcoholic counselor to help the problem drinker and the use of other coordinated services are employed. The psychiatrist, physician, psychiatric social worker and general counselor all work toward the common goal of understanding and helping the alcoholic.

Variety Of Services At Counselor's Hand

Such services as legal, housing, medical, welfare, veteran counselor, mutual aid, credit union and recreation are available to the alcoholic counselor in his efforts to help the alcoholic. The services of the local pastor and Alcoholics Anonymous are also enlisted.

The first results of this comprehensive program were revealed early in 1950 when a study of 71 problem drinking employees was completed. This study revealed that the program was successful, that it was reducing absenteeism, that it was saving employees thousands of dollars in wages.

The study could not reveal the mended homes, the restoration of many valuable men to their jobs and place in society, and other intangibles that were also the results of the corporation's program. In 1948 these 71 alcoholics lost in excess of $23,000. However in 1949 this loss of wages was $13,500. As a result of the company's program, at least 51 have been restored, not only to industry but to their families and to the community as well.

Means For Recovering Much Lost Power

It is becoming evident that American business and industry are beginning to realize that some two million workers are operating far below their potential and that means are now available for recovering much of this lost power. Increasing public awareness that "something can be done about alcoholism" is apparent.

In the magazine, *The Office,* an article entitled "Alcoholism Is A Program For Management" states in its concluding paragraph, "Prevention of Alcoholism—an even more important factor—is again an educational problem in which business can participate directly within its own offices and plants, and indirectly by supporting community activities.

"Disregarding for the moment such valid considerations as senti-

ment and humanitarianism, the rehabilitation of the sick alcoholic is an economic necessity. The precision machinery of private enterprise operates most efficiently when manned by healthy, alert workers."

The church has a major responsibility. While the church is interested in all programs of rehabilitation, it must not lose sight that its main concern is that of prevention. The alcohol problem is serious and cannot be ignored. Too long too many churches have temporized and avoided the problem. The church and its ministry must have a compassionate concern for the victims of alcohol. It should encourage industry and all other agencies who are concerned with this problem.

Prevention: More Than Negative Influence

In Virginia, our Division of Alcohol Studies and Rehabilitation has in the past few years dealt with over 1,000 alcoholics and assisted many of them to find a new way of life and again take their place as responsible members of society. It must be repeated that the major responsibility of the church in this area is that of prevention. The church deals with human nature at its best and worst. It is in a position of unique influence upon the problem drinker and the potential problem drinker. Prevention is more than a negative influence. The church must offer something to fill the place of that which it is trying to prevent.

ALCOHOLIC EDUCATION — A NEED

In the field of alcohol education, we should provide our young people with more facts than just the physiological effects of alcohol upon the human body. We should show them the connection between addictive personalities, emotional health and alcoholism. We should acquaint them with more than just one of the symptoms of alcoholism, which is alcohol itself. We owe them instruction free from fear and prejudice.

We should acquaint them with the causes of the illness which usually go deep into the addictive personality's relationship with himself and the world. We should clearly show them the difference between a sick personality and a healthy one and the paths to each condition. Alcohol education is more than the chemistry of alcohol and its effects upon the human body. It is also a matter of mental hygiene knowledge and practice.

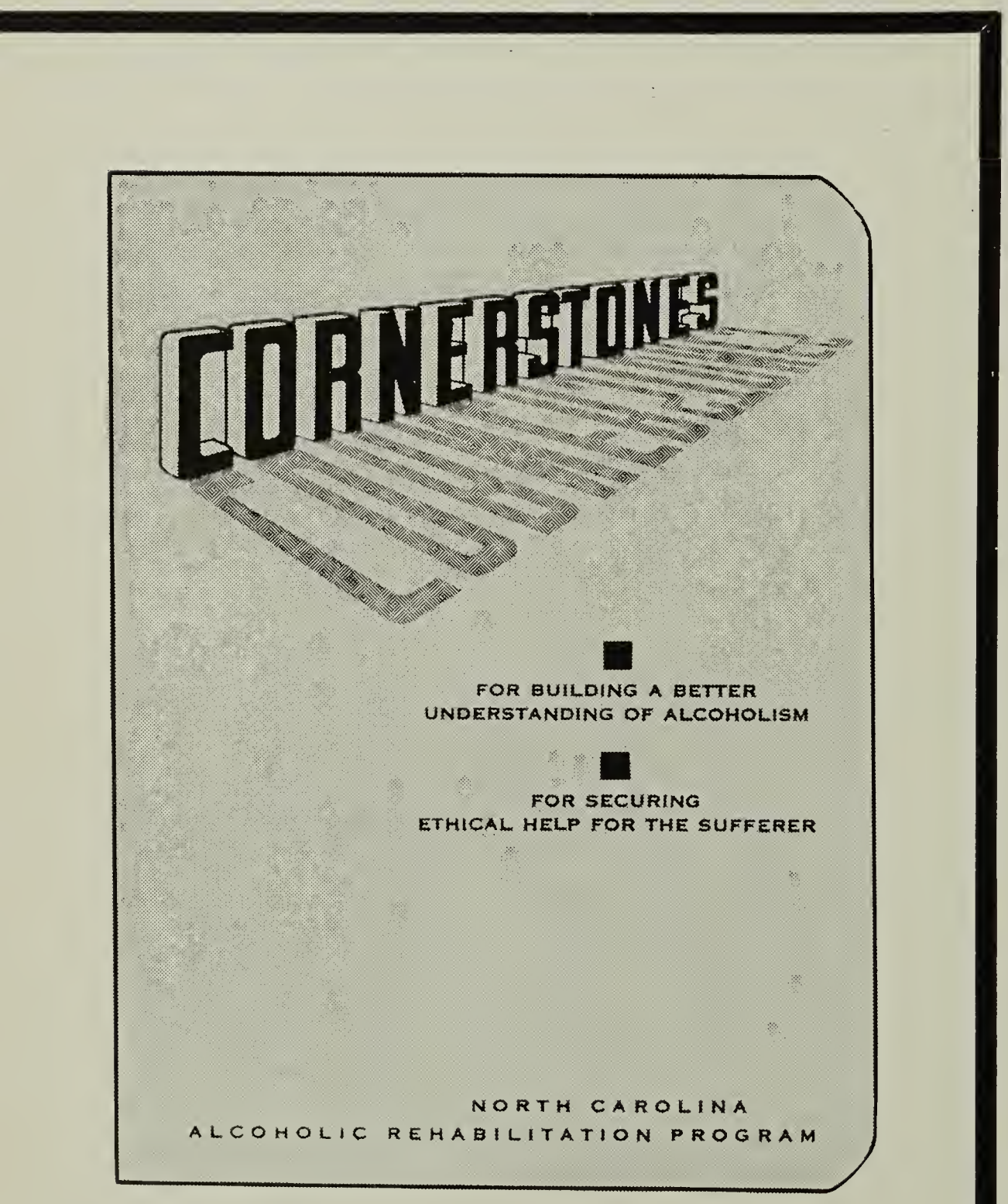
HIGHLIGHTS FROM THE FAMILY MANUA

Now ready for state-wide distribution, the new ARP family manual on alcoholis booklet, the first of its kind in North Carolina history. It gives some basic facts ab sive stages, early recognition, diagnosis and treatment. It also suggests some way might cope with this ageless illness. For a free copy, write Family Manual, Box

The following quotations were lifted from the guide's twelve sections:

What's Wrong With Joe, Doctor?

"Joe is a sick man, Mrs. Doakes. He is a sick man whose excessive habitual drinking is only the symptom of a deeper illness, a stronger need . . . His problem is a form of obsession with alcohol, perhaps, but the drinking is a surface symptom and personality maladjustment is a basic cause. Get at the cause, and the symptom will necessarily disappear from Joe's life."



A Democrat

Alcoholism is no respe class, color, or creed. It' million-dollar industrialis teacher. It can slip up c carpenter, and the painte shop clerk and musician.

Steps Toward

Then came the first *bla* actions after a certain po *drinks* during which the s ones to get an edge on th the black-out and the sne toms.

Some Tea

There are other mighty times have you read a bo —"Cure Drinking Habit i 5 Days—No Nervousness— the one about the "Drunk

There Is Help—

Although there is no fo doctors and clinics, many ment centers frequently u read their literature, learn AA groups refer patients

Some Vital Why

The need for escape drinking. Solitary drinkin found here. The causes f tonous or routine jobs, l business burdens, again t happiness.

Human Person

A new baby arrives, an the parents linger worsh the forgotten four-year-ol affection through his dog shy in his loneliness whic fear, indefinable shame a

Desire Shou

Before he can gain any where through any meth treatment. No one can te his need for help. Such person, the extent of hi under which he is sufferi

Into The Cli

Guidance and care sto meet his problems alone return to the clinic for f received with an open mi Relapses are possible am and professional therapist

A.

is is a 52-page, pocket-size
bo t alcoholism, the progres-
ys he family and the public
918, Raleigh, N. C.

Illness, At Least

er of persons, no caterer to
lemocratic. It can strike the
he stevedore, or the school
he doctor, the preacher, the
It can lure the secretary and

a Insidious Illness

out, the inability to remember
This was followed by *sneak*
ect downed a few early, quick
party." According to Jellinek,
drink are pre-alcoholic symp-

g Temptations

asing temptations. How many
aced advertisement screaming
Days—No Desire For It After
Nausea." Have you ever read
Cured in 24 Hours?"

alistic, Experienced

l connection between AA and
fessional therapists and treat-
people to attend AA meetings,
eir way of life. In like fashion,
doctors and clinics.

A Drama Of Reasons

nother reason for excessive
nd the legendary "binge" are
escape are numerous—mono-
iness or danger, domestic or
eelings of inadequacy and un-

y—A Prime Factor

e four-year-old is neglected as
ully over the bassinet. Soon
rawls within his shell, seeks
stolen cooky jar. He becomes
ventually grows into anxiety,
nate.

Match The Need

od out of any treatment any-
the alcoholic must want the
when the sufferer will realize
l realization depends on the
lness, and the circumstances

And A New Day

hen the person feels he can
the patient "slips," he can
er treatment, and he will be
as the sick person that he is.
the sufferers of alcoholism,
cept this fact realistically.

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Balanced Treatment—Like That Of Butner

Actual treatment at the Center consists of many steps toward emotional and personality health: carefully planned diets, necessary medications and vitamins, stimulating group discussions, films on personality development, private consultations, indoor and outdoor recreational facilities, occupational therapy sessions, and ample time for personal meditation.

Rehabilitation—A New Attitude

There are thousands of "recovered" or rehabilitated problem drinkers who are striking evidence that the alcoholic can become well, can win back his health. Successful treatment and rehabilitation depend greatly upon the attitude of the patient as well as the attitude of his family and friends.

A New Approach To An Old Problem

In the past, many citizens have shown an interest in alcoholism as a social problem, but relatively few have understood it as an illness and the alcoholic as a sick person. North Carolina now has an agency for the public interpretation of alcoholism as an illness and for the treatment and rehabilitation of the alcoholic.

A LEADING FACTOR

For Guidance Toward Sobriety

Every application to the Butner ARC should be accompanied by a social history and a medical history of the patient. The medical history is secured through the family physician. The social history is secured through the County Welfare Department which has trained case workers familiar with the preparation of such histories.

According to the Center's Medical Director, "The social history is important. It is an outline, not to be written on or used as an application blank. The best compiler is the trained case worker. We want the facts, objectively, realistically, honestly. When we get a full picture of the patient's background, the real facts back there, environment, education, vocation, we can give him much more help. The social history gives us a foundation for diagnosis and some areas for guidance toward sobriety."

In answer to many requests, the ARP reproduces here the seven pages of the social history outline. From this information, the ARC physician gains some insight through which to help the sufferer.

BUTNER ALCOHOLIC REHABILITATION CENTER
BUTNER, N. C.

HISTORY OUTLINE

Informants: (Information should be obtained from more than 1 person if possible)

Name
Relationship to patient
Address
Telephone Number
Impression of informants, including:
Attitude toward patient
Length of time known patient
Apparent reliability of information
Powers of observation
Whether emotionally involved

FAMILY HISTORY:

Grandparents:
Paternal and maternal
Birthplace—citizenship if foreign born
Occupation
Education
General health
Specific diseases known suffered from
Cause of death

Father:
Name
Birthplace—citizenship if foreign born
Age: date of birth
Education
Occupation
Personality
Attitude toward birth of patient—general attitude toward sex
Health: specific diseases known suffered from
Cause of death: patient's age at death of father
Duration of last illness

Mother:

Maiden name

Birthplace—citizenship if foreign born

Age: date of birth

Personality

Attitude toward birth of patient

General attitude toward sex

Health: Specific diseases known suffered from

Cause of death: patient's age at death of mother

Duration of last illness

Siblings:

Names—list chronologically including patient

Ages

Health

Did patient share bed regularly at any time for any period with parents or siblings: Did any sexual irregularities result from this?

Adoption:

If patient was adopted, give reasons surrounding the circumstances. What did patient know of adoptive status and how? What was patient's attitude to this knowledge? What was his relationship subsequent to this knowledge to other members of the family? What if parents are divorced explain circumstances, and what was patient's attitude to this? Attitude to stepfather or mother?

Home Situation:

General economic condition of family—income details:

Acreage of farm and if owned

Size of home—number of rooms

Utilities available

Indoor or outdoor sanitation

General type of neighborhood: Did family take any part in community affairs

Any changes in economic standard

General:

History of mental or organic diseases in family—

Example: psychosis, neurosis, epilepsy, cancer, tuberculosis, alcoholism, venereal diseases, crime, etc.

It should be remembered that this outline of the patient's family history cannot possibly include all of the factors which might bring to light important and influencing background features. The above points have been listed merely as a guide for the worker who must use judgment as to whether or not the information obtained is relevant.

PERSONAL HISTORY:

Birth and Early Development:

Date and place of birth, citizenship if foreign born, length of time of family in the community.

Type of labor—instrumental, etc.

Age of walking, talking, teething and weaning

Any difficulty in toilet habits, thumb sucking, enuresis, tantrums, fears, eating habits, sleep, masturbation or sexual experiences

Opportunities for companionship

Most significant person in patient's early life

Relationships in the family group

Parents' attitude toward patient: Such as over protective, dominating, rejection or loving, etc.

Patient's attitude toward parents. Type of response to parents' attitude such as submissive and dependent, aggressive and protesting, evasive and secretive. Favorite parent.

Response to their death (if not living).

Response to punishment: Type and frequency of punishment by parents, which parent usually punished, which parent's punishment resented most?

Siblings: rivalry, jealousy, or favoritism.

Any particular attachments, hostility, dependency, or rejection.

Attaining independence:

How was it achieved, or did patient remain more or less dependent.

Upbringing relationship—include grandparents.

Education:

Type of school

Amount

Accompliahed with difficulty or ease

Interest in any special subject

Ability to get along with teachers and students

It might be found necessary to enlarge upon the educational factor. Some additional features which might be considered are: age schooling began, grade reached, any grades repeated, rating in class, response to situations and increasing competition, why left school, attitude toward teachers, students and studies.

Occupation:

Positions held—salaries

Regularity of work—change of jobs, and reasons for changing

Interest in work

Any trade, skill, or profession
Ambition or aim
Whether housewife or other unpaid occupation
Whether any social security covered employment
Employers estimate of patient

Military:
Branch of armed service—dates
Selective Service
Details
Adjustment to service discipline
Hospitalization during military service
In active combat
Type of discharge
Readjustment after leaving service

Personality and Social Adaptability:
Interest in and attitude toward other people
Seclusive or friendly
Thoughtful of others or self-centered
Dependency attitude
Tendency to dominate or be self-effacing
Tendency to blame others
Friends
Number
Sex
Jealousy
Guilt feelings
Temperament
Moody or even tempered
Explosions of temper
Cheerful and optimistic or pessimistic
Worrier or inclination toward lack of sense of responsibility
Self-assertion
Submissiveness

Sense of humor
Prudish
Degree of achievement and attitude affecting it
Ability to accept and work with things as they are
Utilization of capacities
Over or under self-evaluation
Frustration or feelings of inferiority
Apparent compensatory behavior
Degree of maturity: attitude toward money matters: did patient assume responsibility for housework or chores?
Interests
Cultural—reading, art, music, theatre
Hobbies
Recreation
Types
Sacrifice of play to work
Gambling

Other suggestive points relative to the personality and social adaptability of the patient may be considered helpful: response to criticism, over-sensitive to the opinions of others.

Sexual History:
Married or single
Attitude to sex
Development of sex life: Age of puberty; adjustment to puberty (in women adjustment to menstruation; regularity)
How was sex knowledge obtained
Was adjustment satisfactory
Crushes: Dating habits; type and age of date
Masturbation or other perversions
Patient's attitude to venereal disease
Premarital experiences

Marriage: date
Attitude towards spouse
Attitude of spouse towards patient
Age of spouse
Sexual adjustment in marriage

Patient's attitude to childbirth
Extra marital experiences
Does spouse work outside home
Age of climacteric—any difficulties

Children:

Living
Dead
Miscarriages
Still births
Attitude toward children
Attitude of children toward patient
Attitude of patient to death of any children
Attitude to divorce or separation: Death of spouse: Remarriage

Religion:

Denomination
Attitude
Changes
Conflicts with parents or spouse

Habits:

Alcohol, drugs and patent medicines—kinds and approximate amount consumed
Regular or periodic
Solitary or with others
Effect of drinking on patient
Irritable or amiable
Sleepy or excited
Pathological behavior—assaulting others, etc.
Any known cause for drinking; or what need it fills for him

Anti-social Behavior:

Time, place and nature of any arrests
Charges and sentences
Patient's attitude to own actions
Patient's attitude to anti-social behavior of others and especially members of the family

Medical:

Convulsions
Illnesses
Operations
Accidents and injuries
Venereal
Any marked increase or decrease in weight

Previous Mental Illnesses:

Attacks, dates, durations and description
Hospitalizations, place and date of admission and discharge, condition on discharge

Present Illness:

Date of onset, whether it appeared sudden or gradual. First symptoms noticed. Any delusions shown. If so what the patient said, such as he had enemies. Then his emotional response to it. Was he afraid, angry, elated, or indifferent. Then whether he intended to do anything about his delusions, such as if he thought he had enemies he would get a gun to protect himself or relatives, or was he indifferent to his fate, or did it make him depressed.

Does he hear voices? If so, his attitude toward them as indicated about delusions. If he has no delusions, but his emotions have been affected, in what way. Depressed, elated, indifferent, irritable, etc. Any ideas of suicide.

Any intellectual defects (usually in organic cases) such as disorientation of place, person or time. Confusion, memory loss, impairment of intellectual function.

Reason for patient being sent to a hospital, how he was gotten there and by whom.

Further Information For Alcoholic Patients:

When did patient start social drinking?
When did patient start to lose control of his drinking?
What was and what is at present the amount of drinks consumed?
What type of beverages?
Regular or periodic?
Solitary drinker or with others?
If periodic what seems to be the thing that starts these periods?
How long are the sober intervals?
How long are the sprees?
What seems to put an end to the drinking sprees (financial, social, etc.)?
Any known cause for drinking, or what need it fills for him?
Type of behavior under intoxication—in the past? At present?
Abstinence periods—length (date) Cause—
Attitude of members of family toward patient's drinking.
Economic, occupational, marital, criminal consequences of patient's drinking could be recorded under the pertaining headings of the usual social history.

Philadelphia Hospital Answers Four Questions About Alcoholic Patients

In September, INVENTORY made this statement: "The average North Carolina general hospital usually casts a wary eye at any proposal for the treatment of chronic alcoholism within its plant. In addition to the ruthless stigma many communities attach to the illness, there are always the practical questions of the hospital's administrator and medical staff. Questions of discipline, costs, and reputation naturally arise."

In a prepared statement for the North Carolina Alcoholic Rehabilitation Program, Charles J. Seltzer, president of St. Luke's Hospital in Philadelphia, answers some of these basic questions by describing the Philadelphia hospital's policies and experiences with alcoholic patients. —The Editor

The C. Dudley Saul Clinic at St. Luke's Hospital in Philadelphia opened on June 10, 1946 with a capacity of 18 beds for the in-patient treatment of male alcoholics. We also take female patients, but they are housed on the medical and surgical floors in private rooms of our main building.

We are not entirely satisfied with this procedure for the women, but it is the best we have been able to provide under the existing circumstances. It is our hope eventually to be able to set aside a small section of two to three rooms where women alcoholics can be placed together as the men are in our Saul Clinic.

The Board of Trustees of St. Luke's decided to open its clinic for alcoholics on the basis of previous experience in treating them on an individual basis. The late Medical Director of St. Luke's, Dr. C. Dudley Saul, in whose honor the clinic is named, had begun to treat alcoholics as early as 1936.

To A Special Portion Of The Hospital

As he endeavored to provide the necessary therapeutic procedures to restore them to sobriety, he discovered that it was more difficult to do so when they were provided for in the general floors of the hospital. He became convinced that there was great hope for this type of work if the alcoholics could be segregated in a special portion of the hospital and yet still incorporated as part of the general hospital work.

When the war ended and the applications of girls to enter our Nursing School fell off, we were fortunate in receiving undesignated legacies for a modest amount which enabled us to take two houses formerly occupied by our student nurses and renovate them for use as a clinic. The houses are physically separated from the hospital, but are immediately across the street from it so that they are in effect part of the general hospital organization.

All our food at the clinic, for example, is prepared in the main hospital kitchens and brought in carriers across the street and reheated for serving in a small kitchen at the clinic. All the diagnostic and therapeutic procedures of the main hospital, such as x-ray, EKG, BMR, physical therapy and social

service are available to the patients in the clinic as they are to the patients in the main hospital. In addition, of course, we have available for our patients the professional services of the entire staff. In the event the physicians at the clinic require consultations in any branch of medicine, the chiefs of these various departments are available to the clinic.

Experience has given St. Luke's some interesting answers to questions often asked about alcoholic patients. The following questions were asked by the North Carolina Alcoholic Rehabilitation Program:

1. Are alcoholics obstreperous, obnoxious, aggressive and generally uncooperative patients?

It has been our experience that as a rule the alcoholics when they are cared for in a separate wing or separate building are cooperative and remarkably easy to handle. From time to time a patient will arrive in a belligerent or pugnacious mood, but as he discovers the sympathetic, understanding attitude of the staff of the clinic, he quickly subsides and becomes readily amenable to our procedures.

Where it is impossible to handle him by persuasion when he is perhaps in the most acute stages of alcoholism and either approaching or actively in delirium tremens, it is necessary to use restraint. It is interesting, however, to note that as far as we know none of our patients has ever felt resentful toward the clinic because restraints had to be applied to him in the acute stages of the disease.

Four Criteria For Determining Response

We have made a special study of this problem of what we call "managing" the patients. We have four criteria which we apply to determination of the patient's response to therapy: sleep, nervousness, general attitude and appearance. Each morning each patient is interviewed or visited by one of our staff and he is graded on the basis of these four criteria. Perfect grade is four and lowest grade is one. We determine that a patient is manageable when he has no score worse than two and has at least "2" scores in two criteria. We have found over the years of handling our patients that a patient becomes "manageable" in less than 20 hours.

2. Are alcoholics bad financial risks?

We have found that as a rule the alcoholic is as good a financial risk as any other patient that comes to the hospital. Our program calls for payment of a flat fee of $85 for five days' stay which covers all his routine costs while in the hospital and the professional services of the attending staff.

We are interested in serving those with limited financial means and our Board of Trustees has agreed that the clinic may accept up to 20% of its bed capacity in free or part pay patients. It is interesting to note that never during the more than four years of our activity have we had to go over this figure of 20%. In other words, far from being unable to pay their way, as many people would assume, fewer alcoholics request or get free payment than the Board of Trustees was willing to allow.

By insisting on payment in advance we eliminate many of the difficulties which arise in financial dealing with alcoholics. It should be stated, however, that some latitude is given in enforcing this rule, because we think the

assumption of financial responsibility is a cardinal principle in the recovery program.

3. Is the cost of operating such a facility greater than the cost for other services and does it require more personnel?

Two major costs in operating our clinic are the salaries and food. Our personnel consists of the following: one business manager (part-time), one combined office manager and assistant nurse, one registered nurse in charge of the nursing service and seven former Navy corpsmen whom we call corpsmen; one secretary, one technician, one kitchen maid, one combined kitchen helper and housekeeping helper, and one full-time housekeeping maid. In addition, we have on the payroll one internist, one neuropsychiatrist, a pathologist and a medical director.

Our financial report for 1950 showed the following:

Receipts from Patients	$60,459.01
Accounts Receivable less write-offs	8,634.27
Commonwealth of Pennsylvania for free and part paid patients	940.00
Miscellaneous Contributions and other income	58.48
Total Receipts	$70,091.76
Costs	75,985.56
Deficit	$ 5,893.80

During the fiscal year ending 1950, we treated exactly 900 patients and performed 3884 patient days. This works out by simple division at $19.82 as a cost per patient day. Actually we are only charging $17 per patient day and since some of the patients are free or part pay, you see why we are slightly behind. Our costs are higher than those of the main hospital, because the staff could handle more than the 18 beds to which we are physically limited. Our Board of Trustees, however, considers this money well spent.

4. Does acceptance of alcoholics create an undesirable reputation?

On the contrary we have found that this work with alcoholics has been the greatest good will builder that our hospital has found. We are not a teaching hospital and hence do not rank with the great teaching hospitals of our city nor do we compare with some of the other voluntary hospitals in size. Consequently, there has not been too much to distinguish our care, which we consider excellent, from that of other institutions. The adoption of this program for alcoholics, however, has made us unique among the hospitals of the city in that we have achieved a genuine statue in public appreciation through this specialized work which we are doing.

It, of course, wins the deep and abiding affection and gratitude of patients and their families for what we are able to accomplish and it has generally the approval of church, educational and welfare workers of the city.

SOCIAL CASE WORK ON THE TEAM

The recognition of the variety of causative factors in alcoholism has led many therapists to realize that a one-sided approach to the problem of the alcoholic is likely to be ineffective. The complex of biological, psychological and social bases and implications in every history of alcoholism calls for a multiple approach in each case.

Learning The Patient's Environment

The teamwork approach has been elaborated by J. Thimann. On the assumption that once established, addictive drinking becomes an autonomous disease, independent of its underlying causes, a four-point program has been developed at the Washingtonian Hospital, Boston. First, the elimination of addictive craving is attempted by the conditioned-reflex method. Next, psychotherapy is given, as requisite for the individual. The third point is social case work affecting the patient's environment. This task frequently proves difficult because the alcoholic's near relatives are themselves, more often than not, emotionally immature, insecure, demanding, possessive neurotics.

They may be in need of the patient's dependence on them and, unless they are helped, their problems will hinder the success of the treatment. The patient's environment includes his working conditions, so that at times he must be given vocational guidance. His emotional and social underdevelopment is often seen in fragmented schooling and training. Guidance and encouragement may contribute to new self-confidence and economic and social security. Social and relaxation therapy, the fourth point, includes planned recreational outlets and creative hobbies.

The Teamwork Treatment Approach

B. H. Gottesfeld and H. L. Yager, of the Blue Hills Clinic in Hartford, Conn., have recently described a teamwork treatment approach. They utilize a five-point program of psychotherapy, physical-chemical therapy, family management, substitutive-sublimative treatment, and "total push." With respect to family management, the authors emphasize the frequent need of psychotherapy on the part of the patient's close relatives. Unless they can be brought cooperatively into the picture, the patient's success in the clinic or hospital situation is endangered.

"It is the area of sexual aggression versus sexual passivity which often brings out the urge to drink," they point out, and this makes the family situation of prime importance. Without effective social case work the resolution of these problems is extremely difficult. The substitutive-sublimative treatment includes the cultivation of hobbies, social contacts and group activities, as well as the satisfaction of personal religious needs. The authors emphasize the importance of cooperation between medicine and social work.

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Balanced Meals Await The Patient

Fifty years ago when the town's "habitual drunk" died of a "wet brain" or a "soaked liver", it was generally concluded that alcohol had taken another victim. Medical science currently shows that many of the organic deteriorations once blamed totally on alcohol are actually the direct result of nutritional deficiencies in the chronic alcoholic's daily diet.

Many problem drinkers fail to eat properly a great deal of the time, hardly at all during heavy binges, and soon find themselves suffering from excessive nerve conditions or painful organic disturbances. These conditions are usually the body's way of crying for a balanced diet of vitamins, minerals, proteins, fats, carbohydrates, etc.

Well-Balanced, Highly Appealing Meals

When a patient arrives at the Butner Center, he is given any necessary vitamin injections his condition calls for. In cases of extreme dietary requirements, like diabetes and cirrhosis of the liver, the patient is given special attention. The Center's regular daily menu is based on dietary allowances recommended by the Food and Nutrition Board of the National Research Council.

According to Miss Faye Williams, dietitian of the State Hospital at Butner, the seven basic foods are used as much as possible in providing ARC patients with well-balanced and highly appealing meals. The basic foods include these groups:

Group 1, Green and yellow vegetables—raw, cooked, frozen or canned;

A dinner scene at Butner. Mrs. Marcus Wall, dining room hostess, serves patients from cafeteria window in the background.

Group 2, Citrus fruit, tomatoes, raw cabbage or raw greens; *Group 3,* Potatoes and other vegetables and fruits; *Group 4,* Milk and milk products as a beverage or in cooked foods; *Group 5,* Meat, poultry, fish, eggs, dried beans, peas, nuts, or peanut butter; *Group 6,* Bread, flour and cereals, whole grain, enriched or restored; *Group 7,* Butter or fortified margarine.

The patients are given average size servings but may have additional food if desired. They are given milk and fruit juices between meals or at bedtime. According to Miss Williams, an average menu for six days at the Center includes the following meals:

Breakfast: Tomato juice, dry cereal, eggs, bacon, buttered toast, jelly, coffee, cream, sugar, milk; *Lunch:* Pork and veal loaf, potatoes, cabbage, spiced beets, cornbread, banbury torte with custard sauce, milk; *Dinner:* Chicken pot pie, French fried egg plant, bing cherry salad, wholewheat rolls, jelly, milk, butter.

Breakfast: Oranges, dry cereal, hot cakes, butter, syrup, sausage, coffee, sugar, cream, milk; *Lunch:* Pork shoulder steak, corn pudding, green beans, cornbread, sliced tomatoes, gingerbread, milk; *Dinner:* Cream chip beef on toast, peas and carrots, stuffed prunes with sliced peach salad, biscuits, milk, butter.

Breakfast: Grapefruit juice, dry cereal, milk, eggs, bacon, toast, butter, jelly, coffee, sugar, cream; *Lunch:* Weiners, potatoes, pintos, turnip greens, cornbread, pineapple upside down cake, milk; *Dinner:* Oyster stew, Spanish rice, lettuce salad, all-bran muffins, milk, butter.

Breakfast: Orange or grapefruit juices, dry cereal, milk, eggs, bacon, toast, butter, jelly, coffee, sugar and cream; *Lunch:* Spareribs, candid yams, kraut, succotash, cornbread, butter, apple pie, milk; *Dinner:* Hamburgers, potato cakes, cole slaw, rolls, butter, milk.

Breakfast: Grapes, dry cereal, milk, sausage, hot cakes, butter, syrup, coffee, sugar, cream; *Lunch:* Fried chicken, rice, gravy, green beans, buttered cauliflower, lettuce and tomato salad, mayonnaise, biscuits and butter, cake with caramel icing, milk; *Dinner:* Veal and celery salad, potato chips, cheese toast, celery and carrot strips, cookies, milk, crackers.

Breakfast: Tomato juice, dry cereal, milk, eggs, bacon, toast, butter, jelly, coffee, sugar, cream; *Lunch:* Fried chicken, rice, gravy, green beans, buttered spiced beets, cornbread, butter, dutch apple cake, milk; *Dinner:* Liver and onions, buttered peas, lettuce salad with French dressing, rolls, butter, preserves, milk.

The superb work Miss Williams is doing in supplying the Center with attractive meals each day is recognized in scores of letters that come to the ARP office in Raleigh. A glimpse at one or two comments only begins to tell the story:

A *Stovall* patient says: "The food is good, beds are comfortable, lounge and general atmosphere very relaxing."

An *Asheville* patient writes: "Feel the best I have felt in 25 years—almost unbelievable—gained 16 pounds while at Butner."

From *Snow Hill,* a patient speaks of vacation feeling: "I could talk a long time about Butner. It is one of the best hospitals I have ever seen and the treatment and food are excellent. I felt like I was on a vacation for the full 28 days."

CLEARING THE CONNOTATION

Alcoholism As An Illness —

By A Member of Thi

As a preface to the following article, it should be distinctly understood that the opinions expressed and the conclusions drawn are those of the writer as an individual and are in no way connected with the principles or doctrines of any organization whatsoever.

A few weeks ago I was called to the home of a friend who was in pretty bad shape. He had been drunk for about two weeks and was still intoxicated. When his wife and I went into his room, about all he could say was, "I'm a sick man . . . I'm a sick man and I can't help it."

As I was leaving, his wife rather bitterly exclaimed, "What I have against this modern conception of alcoholism is that it offers such a good excuse to stay on a drunk. Of course Jim's sick now. Anyone would be who had been drinking for two weeks and eating nothing. But between drunks he is as healthy as a horse. He may not be able to help it, but you can't tell me that he drinks because he's sick or that alcoholism is a disease!"

I believe this is a good illustration of the grave misunderstanding of the alcoholic's problem which may be caused by loose or careless nomenclature. Such misunderstanding may cause grave loss of or damage to the interest and support which any alcoholic educational program must receive from the general public.

To the lay mind, illness or sickness or disease carries a connotation of the physical and since they cannot conceive that compulsive drinking constitutes a physical illness, they often refuse the whole program based upon a premise of sickness.

The Y.M.C.A., in its three point program, stresses the three sides of mankind: Mind, Body and Spirit.

If the mind is sick, then we ordinarily class the person as insane.

If one's body is sick, this is an organic illness and requires treatment accordingly.

AS PART OF THE ARP'S . . .

Due to production delays, the ARP's pocket-size Family Manual, CORNERSTONES For Building A Better Understanding of Alcoholism and For Securing Ethical Help For The Sufferer, was not ready for distribution until the last week in December. The ARP is grateful for the scores of requests over the past seven weeks. All requests are now being fulfilled on the day of their arrival. INVENTORY refers interested readers to the quotations from the manual on pages 16 and 17 of this issue.

Or An Emotional Sickness

ALISBURY A.A. GROUP

While I have no medical training, I have talked to many trained medical men, psychiatrists and especially trained social workers. I have read almost everything lately published upon the subject of the possibility of physical illness causing compulsive drinking from a scientific standpoint.

To date I have been able to find absolutely no competent opinion or authority that the bodily or physical make up or metabolism or allergy to alcohol of the alcoholic is any different from that of the social drinker or the total abstainer. All qualified scientific opinion seems to point to the fact that alcoholics, as a class, are as normal physically as anyone who may read this article.

Now let us change "spirit" for "emotion." Their meanings are not widely different according to many lexicographers.

Unquestionably the alcoholic is *emotionally* maladjusted or sick. Emotionally he is diseased. Every bit of scientific knowledge and data accumulated to date proves this beyond reasonable doubt. If we say, therefore, that the compulsive drinker is "emotionally sick," then we are indisputably correct and no one may rightly take exception to the diagnosis. It will lead to no misunderstanding. It will cause no one to reject an educational plan based upon this premise because they gravely doubt his basic physical illness.

It is a convincing and possibly harmless excuse for the alcoholic to claim an allergy to alcohol when refusing a drink; however, this is supported by no scientific evidence.

I do not mean to seem pedantic and to wrestle with words or exact definitions, but I realize that the lay mind, associating sickness, illness or disease with man's physical side, no matter what we may *mean,* unless we qualify our statements, will cast grave doubts upon our claims. The cause of the alcoholic may thereby be rendered real harm.

. . . INFORMATIONAL SERVICES

A new, 36-page verbal and pictorial brochure of the Butner Center has been compiled from past issues of INVENTORY and current treatment data. Portraying Butner as a place of both restorative atmosphere and systematic treatment, the booklet interprets Butner's admission, group discussions, emotional health films, planned diets, private consultations, recreational activities, occupational therapy, rules of conduct, etc. For a free copy, write Butner Brochure, Box 9118, Raleigh, North Carolina.

Hangover Treatment Often Becomes Therapy For Underlying Conflicts

The alcoholic hangover, or the "morning after," has traditionally been a subject for amusement. For the alcoholic, however, the hangover state is a recurrent painful experience. The search for adequate treatment of this condition goes back to ancient times. M. Moore reports on a classic Chinese legend concerning a certain kind of precious stone which, when placed under the tongue of the afflicted, relieved the symptoms promptly. Less magical was the special fish soup recorded as given to the poet Li Po to put him on his feet in an emergency.

A. P. McKinlay reports, after Aristotle, that the ancient Greeks found relief from headache in the hangover by binding their temples tightly. The ancients also made use of ointment in combating hangover headaches. According to T. D. Crothers, the treatments used in ancient Egypt included the forcing of fluids, induction of vomiting, enemas, cold showers, massage, flagellation, and steam baths. In medieval Europe vomiting was induced for the morning-after condition and "pick-me-ups" were used (Riddell).

Modern Treatments Of Hangover

In modern times the recommended treatments of hangover include the forcing of fluids and the administration of vitamins, salt, sugar and heart stimulants as well as other medication (Carver).

Deeper consideration of the condition in which the alcoholic finds himself after a bout has recently been advanced by G. Lolli (New Haven, Conn.). He believes that the treatment of the hangover should be designed carefully not only with a view to relief of the immediate discomfort of the patient, but also as an introduction to the understanding and treatment of the patient's alcoholism itself.

Lolli describes the hangover as a classical example of a psychosomatic condition. It represents a combination of physiological symptoms resulting from the direct and indirect pharmacological action of alcohol, and of psychological symptoms characterized by the loss of self-esteem and guilt feelings. Treatment of the hangover should therefore be directed along psychosomatic lines.

Establishing Physical Comfort First

In the early stages of the hangover the physiological misery often outweighs the psychological one. A relative degree of physical comfort must be established before a psychological approach can be attempted. The patient is usually in need of sleep; sedatives should therefore be administered, the choice of drug depending on the characteristics of the individual. In order to reduce the patient's anxiety, mild sedation may be continued when the patient is awake.

A combination of atropine, ergotamine tartrate and a barbiturate is recommended by Lolli as particularly effective for the control of the vegetative symptoms of a patient in hangover. Fatigue may be controlled by the ad-

ministration of amphetamine sulfate. A diet rich in slowly absorbable carbohydrates and the administration of atropine sulfate gives good results in cases of fatigue due to low blood sugar.

Prolonged lukewarm baths have a favorable effect on the transient rises in blood pressure which are frequently observed as a consequence of emotional tension. The prescription of a diet adjusted to the individual case, sometimes supplemented by vitamins, is important from the physiological as well as the psychological point of view. Other measures aimed at specific disorders should be initiated at the same time.

Hangover Often Opens A Gap

Psychotherapy practiced during the hangover stage should, as always, be preceded by a dynamic evaluation of the problems underlying the patient's addiction. Lolli emphasizes the finding that significant material which may be inaccessible at other times can be elicited from the patient in hangover because of the pharmacological action of alcohol on the cortical centers. In addition, the physical and mental pain and the resultant need for help in the hangover, often outweigh the aggressiveness which at other times prevents the alcoholic from cooperating with the therapist.

The aim of psychotherapy in the hangover situation, according to Lolli, is to restore equilibrium between forces of control and impulses striving for expression. Frequent contacts with the patient are desirable at this stage. Efforts should be directed toward reducing tensions and increasing the individual's control over them.

Therapy Toward Basic Conflicts

The verbalization of experiences and emotions which preceded the bout should be kept on an emotional rather than on an intellectual level. Under the emotional stress of the hangover situation old problems come to the fore which can influence the solution to newer ones. Thus the treatment of the hangover becomes therapy directed at the basic conflicts underlying the individual's addiction.

In experience at the Yale Plan Clinic the adequate management of the hangover has resulted in permanent sobriety in some cases and in a definite improvement in the drinking pattern of many patients. Lolli believes that even when therapy fails the value of the data gathered in the hangover situation is sufficient to justify the statement that a thorough study of this significant episode in the life of the alcoholic always adds to his chances of eventual recovery.

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PREVENTION: AN AGELESS QUEST

Can alcoholism be prevented? You get different answers to this, depending upon whom you ask.

The medical researcher answers no, not now, because he hasn't found out *why* some people drink immoderately. True, some worry or conflict is likely to lie at the root of an alcoholic's problem, but the same worry or conflict can be found in many a non-alcoholic. Why does one troubled person become an alcoholic while another remains a moderate drinker or an abstainer?

Detecting The Peculiarity

Perhaps it is because of some peculiarity in the body; if this could be found, it might be simple to develop a medicine that would actually cure alcoholism. Further, if the peculiarity could be detected early enough, potential alcoholics could be warned never to drink. Or the disturbance may lie not in the body but in the mind, or in both. At any rate, the research worker has been concerned up to now much more with the diseases of alcoholism than with the basic cause of alcoholism itself.

The temperance society worker or sympathizer has another answer. He believes that the best way to avoid alcoholism is for people to decide not to drink; others would go farther and make it impossible for people to drink.

Harder To Take Than Vaccine

Other authorities join the medical researcher in asking for research funds, but assert that alcoholism can be prevented even in the present state of our knowledge. Their preventive measure is much harder to take than a vaccine, but since it is offered by some of our wisest and most enlightened teachers and doctors and ministers, perhaps we should consider it carefully before brushing it aside.

It is the building of a society in which the individual is better fed and housed, has better medical care, has better facilities for mental hygiene, has fewer money worries, and has the facilities and the encouragement to engage in recreational activities besides drinking.

"Not Only A Medical Problem . . ."

The public is too much divided between those folks on the one hand who think they have all the answers to the problems of alcoholism and those on the other hand who think there is no problem. The facts show that both groups are quite wrong in their judgment. Alcoholism is not only a serious medical problem but also a very serious social and public health problem.

But little progress has been made toward prevention because there is no way of being sure what particular drinker, given certain conditions, will or will not become an alcoholic. At the same time it is clear that the use of alcohol has a very long history in human society and that it is Utopian to think that the social problem can be solved simply by hoping that people won't use it at all.

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—Excerpt from *Alcoholism Is A Sickness* by Herbert Yahres.

PATIENCE VERSUS PRESSURE

In a recent statement to INVENTORY, Dr. Lorant Forizs, medical director of the Butner Alcoholic Rehabilitation Center, put new emphasis upon the Center's admission policy.

He said, "Admission to Butner's ARC must be voluntary. The nature of our treatment makes this policy necessary. Experience has taught us that the patient who comes to Butner under pressure from his family or a judge responds to the treatment far less readily than the patient who comes out of his own completely honest desire and need."

In a recent study of the reasons Butner's treatment is available only to those who volunteer for it, INVENTORY found some interesting results. Each patient must want help. It is unfair to pressure him into any false desire. Undue pressure is unfair to him, to his family, to the public, and to the Butner Center and staff.

There are four reasons why undue pressure is unfair:

1—It is unfair to the basic principles of successful diagnosis and treatment of any emotional sickness because it is a false motivation. A patient must want help as much as he needs help.

2—It is unfair to the average alcoholic because of his nature. His susceptibility to pressures is matched only by his later explosions that result from undue pressure.

3—It is unfair to the morale of those Butner patients who are sincerely seeking restoration. It destroys the Center's atmosphere and esprit d'corp and wastes the time of a staff urgently needed by sufferers who really want help.

4—It is unfair to the sufferer's economic condition. When he enters Butner as a so-called voluntary patient and then leaves two or three days later, he is paying 72 dollars for treatment he never received or wanted.

When a patient is "fooled" or "pushed" into going to Butner, he soon learns he is fooling no one but himself and those who sent him. He soon learns that the genuine volunteers are at Butner because their *desire* has at last caught up with their *need.*

Butner is building its reputation upon an honest service to those problem drinkers who honestly want that service. The Center's staff strongly suggests that patience builds more desire for treatment than pressure.

TREATMENT IS VOLUNTARY, DESIRE IS COMPULSORY

INVENTORY

If we are to understand the illness of alcoholism, we must take an inventory of what we know and don't know about beverage alcohol and human personality.

If we are to solve the problems of alcohol, we must identify ourselves with the illness of alcoholism. Major and *curable* maladies of today were considered incurable for years, until society chose to tackle them rather than avoid them.

Such identification takes teamwork. It takes the hospital and its physician, the church and its minister, Alcoholics Anonymous and its experience, the family and its newspaper, the public school and its teacher, the radio and its public forums, the health, welfare departments and their trained case workers.

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Mrs. Mary P. Douglas
Libraries Supervisor
Raleigh, N. C.

INVENTORY

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

Published By THE N. C. ALCOHOLIC REHABILITATION PROGRAM

Vol. I MARCH, 1952 No. 6

"For the public, whether in
he school room, the church,
he factory, the hospital, or
he home."

Summer Studies

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TREATMENT REHABILITATION EDUCATION PREVENTION

INVENTORY
A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

VOL. 1 NO. 6

MARCH, 1952

RALEIGH, N. C.

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SANTFORD MARTIN, JR.....*Editor - Information Director*

LORANT FORIZS, M. D.....*Medical Director, ARP*

This journal is printed as a public information service, currently serving 12,000 readers. Free upon request. Write: INVENTORY, Box 9118, Raleigh, North Carolina for a permanent place on the mailing list.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C., UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

Searching For The Roots

At the heart of the Butner teamwork method of treatment for alcoholism, there are two mediums through which the staff and the patients work toward further understanding of the emotional and personality problems represented at the Center. They are films and group discussions.

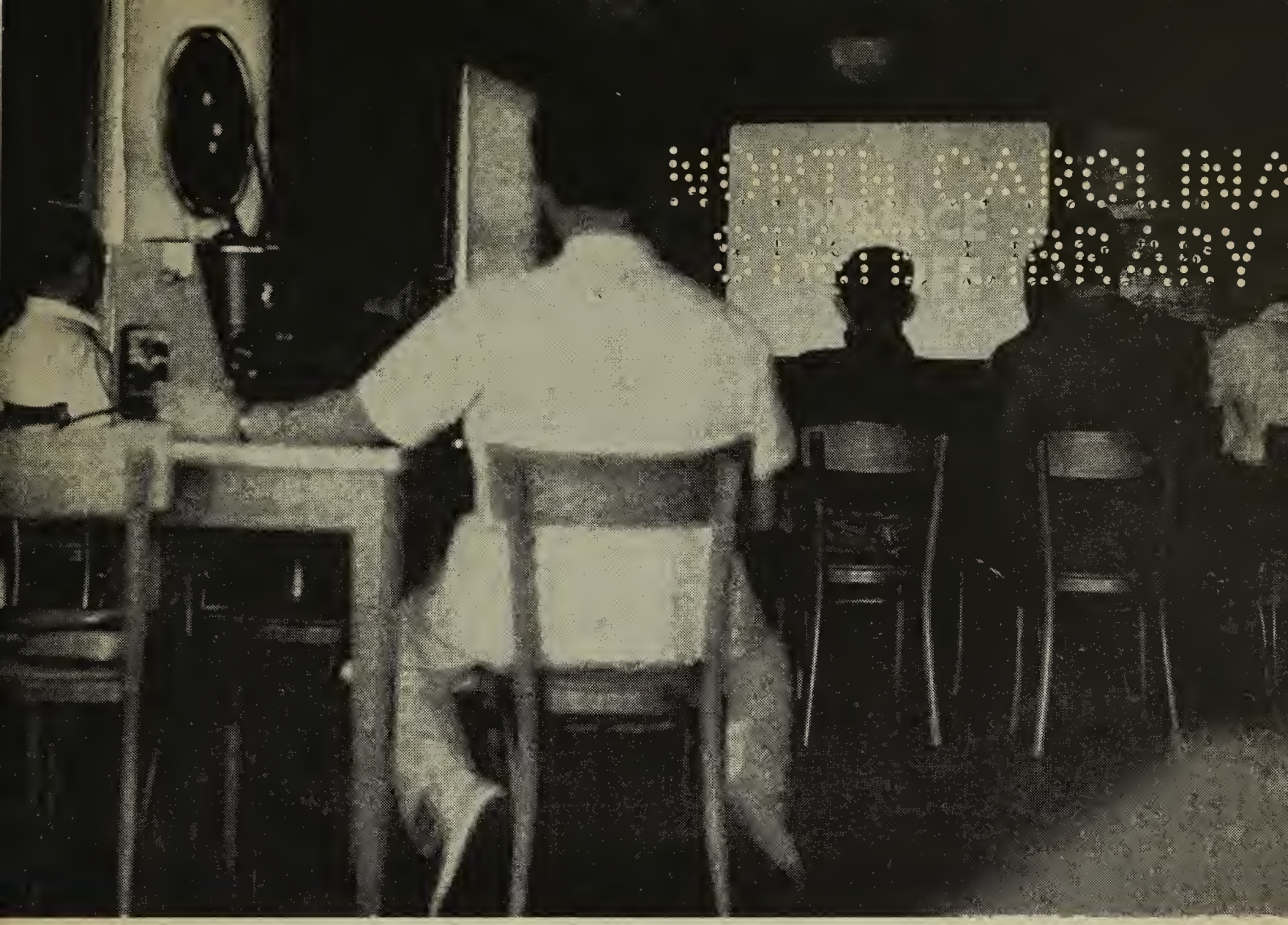
After being noticeably impressed by the general atmosphere at Butner, a patient once took this view of the films and group therapy:

"Coinciding and running parallel with the program designed for our physical restoration is the program to aid and assist in re-establishing in the patient a proper perspective of life. In this program we see movies four days each week depicting the effects and reactions caused by the use of alcohol.

"Other pictures show the various situations in the life of an individual which may be the basis of future alcoholism. These pictures, we believe, are shown not only to let the alcoholic see the deteriorating effects of excessive alcohol upon his physical system, but also to enable him to search himself to determine if some similar situation in his life is not the basis of his own alcoholism.

"After each picture, the entire group of patients together with a doctor, social case worker, or other person meet in the dayroom for an open forum discussion of the picture and its meaning to the patients. By this exchange of ideas and views, each patient may get new thoughts and slants on his own problem which may aid and assist him in his own difficulties. The trend of the whole program is that of suggestion and assistance rather than berating and coercion."

Shown twice to all patients who remain for the 28 days of treatment, the series of eight films are presented in two-week cycles, on Monday, Wednesday, Thursday, and Friday mornings. The pictures include such topics as



Emotional Health, Feeling of Rejection, Over-dependency, Feeling of Hostility, Meeting Emotional Needs in Childhood, Preface to a Life, Alcohol and the Human Body, and Alcohol and Cats.

The emotional health films deal with personality development in various situations, showing how the human personality is affected by the attitudes and actions of the family, the friends, and the neighbors. Tracing distinct cases from birth through childhood to maturity, the films point up the need for acceptance, security and relative independence in a growing child.

They point out that emotional upsets are common, that to seek help for such conditions is an indication of good judgment rather than weak character. They show the everyday do's and don't's that affect the mental growth and behavior of a growing child. They show how a person's capacity for love and friendship can remain undeveloped because of feelings of hostility, hurt, and resentment acquired in early life.

The film on alcohol facts explains the effects of ethyl alcohol on the human body, describing its characteristics and how it is made. It traces the course of alcohol through the body until it either oxidizes or escapes and shows the effects of alcohol on the brain. It also dramatizes briefly the case of a problem drinker, including a treatment.

The connection between the emotional development of a child and the alcoholic sickness of a middle-aged man might not be seen at first glance. But the group discussions following the films stimulate in many patients a healthy search for any roots in their own emotional backgrounds that might be a factor in their sickness.

With the help of the Butner team, some patients find those roots for the first time, and from there a new trail is often blazed.

Alcoholics Anonymous Life Creates New Men Out Of Veteran Prisoners

By Prisoner No. 16999
Minnesota State Prison

It was a warm, sultry Saturday afternoon in August, 1947. Two members from Alcoholics Anonymous Groups in the Twin Cities of Minneapolis and St. Paul and eight perspiring, slightly apprehensive inmates were gathered in the visiting room at Minnesota State Prison for the first AA meeting in the institution . . . On another Saturday afternoon in August, 1951, Warden L. F. Utecht took the rostrum to welcome 170 inmate members of the MSP AA Group and some thirty members from outside Groups throughout the state to the Fourth Anniversary Meeting. During those four years, a new and encouraging chapter had been written in the rehabilitation of alcoholic criminals in Minnesota.

Two Factors: Official Interest, Outside Help

In the formation and progressive functioning of a prison AA Group, two factors are essential. One is genuine official interest and cooperation, plus an understanding, enthusiastic Group sponsor of executive rank. The second factor is the help of outside AA Groups in furnishing speakers and counselors who can advise and encourage members of the prison Group. The MSP Groups have been fortunate in having Warden Utecht as sponsor from the start. Although he is not an alcoholic, he has given unstintingly of his time and personal effort to the Groups' welfare.

State Board Of Parole Lends A Hand

He addresses the Groups frequently and is always on the alert for new policies which will enable the Ingroups to function more effectively. The interest of Mr. Gordon S. Jaeck, chairman, and other members of the State Board of Parole, as evidenced by their willingness to address the members regularly and contribute articles to the Group booklet, has been a noticeable factor in the progress of the Groups.

From the start, the MSP Groups have enjoyed wholehearted, enthusiastic support from AA Groups in nearby Minneapolis and St. Paul. A number of members of these Groups have acted as speakers,

counselors, job hunters, and family liaison men from the beginning. They have been active in arranging parties of visitors for meetings so as to assure a continuous flow of new ideas and AA practice for the inmate Groups. Their devoted and unselfish help has been the keystone in the development and progress of the MSP AA Groups.

At present the AA Groups here in the Minnesota State Prison have a membership of 230 men, out of a prison population of slightly over 1000 inmates. The Inside Group numbers 189 and the Farm Colony Group, outside the walls, 41 members. Membership in both Groups is strictly voluntary and the Groups operate under the same policies as most outside AA Groups. Weekly meetings are held, the Inside Group on Saturday afternoons and the Farm Colony Group on Sunday evenings.

The meetings are attended by delegations of members from one of the Twin Cities Groups, who act as guest speakers and discussion leaders. These visitors come on a rotating schedule—from the Minneapolis Group one Saturday, the St. Paul Group the next, and the Midway Group the next. One of the most important factors in the growth and progress of the Prison Groups have been the wonderful cooperation and interest of these outside visitors.

Pen Pointers: A Helpful Link Inside And Out

In the matter of qualifying outside visitors and other general policies, Warden Utecht, as sponsor of the prison Group, acts as arbiter and advisor. As a result, there has never been a case of major trouble in connection with the attendance of visitors from the outside.

The Groups put out a bi-monthly booklet, *Pen Pointers,* which allows the interchange of ideas and methods among the members. Through the cooperation of the Warden, the booklet is printed in the Prison Print Shop by inmate members. During the two years it has been published, *Pen Pointers* has proved invaluable in promoting interest and morale in the Groups, as well as being a helpful link with outside Groups and individual AA's all over the country.

Why AA in prison? A good question. What need for a therapeutic program for alcoholism in a place where access to alcohol is impossible? Does this not automatically take care of the drinking problem of the men? Dry them out so they will be able to resist the temptation to drink when released? At first glance it seems it should, but in the light of present day knowledge of alcoholism, this is not enough.

Medical men are generally agreed that compulsive drinking is the

result of an emotional disorder—not a physical craving. In accepting this thesis, it becomes evident that mere denial of beverage alcohol can have no effect on the basic causes of alcoholism. A therapy directed at clearing up these emotional conditions—often aggravated by imprisonment—is imperative if the illness is to be arrested or controlled at a point which will allow the individual to live normally.

The Alcoholics Anonymous Program meets the need for this type of treatment ideally—especially under prison conditions. Warden Utecht puts it this way:

"The AA Program seems to offer these men an *acceptable* bridge for a return to rational thinking and the right moral values of which most of them are acutely conscious. That last may sound paradoxical, but observation leads me to believe a great many of these men became alcoholics, then criminals, through their efforts to escape or deaden this sensitivity to an ingrained sense of right and wrong.

A Boon To Prison Administrative Officials

"This AA deal appeals to prison inmates because it is (1) strictly voluntary, (2) it enables them to compromise deep-seated prejudices regarding "religious" or "do-gooder" reformation efforts, (3) they can unload and discuss their problems with others who are in the same boat and who can understand their emotions, (4) they have convincing proof of the efficacy of the AA Program in the person of successful, happy outside visitors, and (5) they are responsible only to themselves and other inmates for their progress toward the objectives of the Program.

"For these primary reasons, this AA Program is a boon to prison administrative officials. I believe it is safe to say a sizeable segment of the population in any prison is composed of men who have been committed because of violations induced by excessive drinking. Of course, all are not alcoholics—but our experience has led us to the conclusion that a large majority of them are. Taking Minnesota State Prison as an example, the membership of the Alcoholics Anonymous Groups—self-admitted alcoholics—stays at a steady ratio of around 20 per cent of the total population.

"Among the advantages this AA Program brings, from an administrative standpoint, the following have been most notable in our experience. It is a means toward rapport between officials responsible for rehabilitation efforts and inmates that has been noticeably lacking in the past. It also helps with men who are not alcoholics. The examples set by AA members encourage others to disregard the

negative attitudes of some associates and to make use of the facilities available to help and improve themselves while here.

"This has resulted in more cordial relations between guard personnel and the inmates and has made possible a number of relaxations in regulations which have benefited all inmates. In short, we have found the presence of an active, large and cohesive group of inmates flying right and trying to improve general conditions by first improving themselves, such as our AA Groups, is a steadying influence on the whole inmate body and a great help in harmonious operations.

Many A Marriage And Family Preserved

"In addition, we have found the AA Program a wonderful deterrent to the breaking up of marriages and families. Many a marriage has been preserved and many a family is still intact only because of the remarkable changes evident in these men as they take hold of the AA Program in here. Wives and mothers are encouraged by this

FOR BETTER ALCOHOL EDUCATION

A new organization designed to aid schools in developing techniques and materials for instruction about alcohol is now in operation. Known as the AAIAN, the Association for the Advancement of Instruction about Alcohol and Narcotics is located at Yale University and serves as a clearing house for information on alcoholism and drug addiction.

Bulletins and reports concerning research activities and experimental teaching are distributed at frequent intervals to members. Membership in the organization is open to individual, private, and public school teachers, supervisors, administrators, including health educators, school physicians, school nurses, and agencies concerned with prevention and control of public health disorders.

The new association grew out of a need expressed by many teachers in various parts of the country for information suitable for classroom instruction on alcoholism and drug addiction. Although there are basic physiological and social differences between the use of alcohol and the use of various narcotic drugs, all states place these topics together as a responsibility of the school.

This has caused misunderstanding among teachers and the public in general and has resulted in a negligible amount of effective instruction in the classroom. For membership information on the AAIAN, write Raymond G. McCarthy, 52 Hillhouse Avenue, New Haven, Conn., or the ARP, Box 9118, Raleigh. Renowned authority on alcohol problems and executive director of the Yale Plan Clinic, McCarthy is executive secretary of the AAIAN.

betterment in their menfolk to a renewed hope for the future and are inclined to give the husbands and fathers another chance. The following letter is typical of many I have received:

> 'As the wife of one of your AA members, I can truthfully say I am very grateful to you people who have helped my husband overcome his shortcoming of drink and put his heart at ease . . . I am certain that other wives, mothers and sweethearts will agree with me that AA is a wonderful program and I, for one, say: "Hats off to you fellows" . . . Congratulations again, and keep up the good work you are doing in helping my husband and me to see a much brighter and happier future for our children.
>
> Thankfully yours,
> Mrs. G—R—'

"Incidentally, this man has been on parole for some time and all his wife's hopes for the future are being fulfilled in his conduct and industry. These are the dividends which inspire us to even greater efforts to bring the AA Program to every man in this institution whose past record indicates a need for it."

"Marked, Startling Changes Have Been Occurring"

Members of the AA Group receive no special consideration from the State Board of Parole. Individuals are judged solely on their attitudes, their work and conduct records, and activities in inmate affairs. Also important are the sponsorship which the inmate will have, the environment and associations to which he will be going upon release. However, time has proved those men who have had the benefit of AA membership acquire the qualities essential to favorable consideration by the Board. This can best be illustrated by the following excerpt from a published article written by Mr. Gordon S. Jaeck, chairman of the State Board of Parole:

> "Marked and almost startling changes have been occurring in men of AA as the program takes hold of individual lives. These changes are evident to us as we see members appearing at second or third Board hearings. The changes are significant and vary with each individual AA member. In each, however, there is a common denominator characterized by quiet surrender to His power, a restored and revitalized self-confidence, and an unwavering determination to live on the outside all Twelve Steps as they have seen them exemplified in the faithfulness of the men from outside AA Groups who come inside week by week. As

these changed men leave the room, Board members are heard to remark, 'What a difference there is in that man'."

Members of the prison Groups have found a ready welcome in the AA Groups throughout the state upon their release. Often, prior to that release, members of those Groups have given generous help in arranging for sponsorship, job finding and various other matters incidental to parole procedure. The availability of AA environment, counsel and guidance in the re-orientation of paroled men to civilian life has played a vital role in the success of most of the "graduates" from the Prison AA Groups.

From August, 1947 to August, 1951, 401 inmates joined the AA Groups. Of this number, 105 voluntarily dropped out, 52 were transferred to the Farm Colony outside the walls, and 77 were released on Paroles, Work Releases, or Discharges. No information is available on the records of the fifteen men out on discharges.

The records covering the 62 men released on Paroles or Work Releases show that sixteen were returned for violation (mostly because of a return to drinking), five of these charged with new crimes. The remaining 47—about 74 per cent—have become useful citizens, successful in a variety of occupations to a degree that an impressive number have been discharged from conditional release and full rights restored to them.

"Why AA In Prison?"—An Answer

This ratio of AA members making good on conditional releases is not exceptional in comparison with parole statistics in general. However, considered from the standpoint that Stillwater is a "graduate" prison and that most of these men were chronic "repeaters" serving time for the second, third, fourth, or more offenses, it is impressive. These are men who, on the basis of past performance, would have been sure bets to violate parole or get into new difficulties with the law. The fact they can go out and by following the AA Program lead sober, industrious, law-abiding lives, would seem to answer the query "Why AA In Prison?" in a manner decidedly beneficial to society.

The Minnesota State Prison AA group is not unique. It is only one of many such groups in prisons all over the country. Its story is no better or no worse than others and is given here as a matter of public information. There is a place for an AA Group in every penal institution. In those sections where they have not been formed, penal officials and outside AA Groups will find an interesting and fruitful task in bringing them into being.

Butner Psychological Tests Designed To Show Different Personality Types

By John Mendenhall
Butner Psychologist

The burly man with his deep, resonant voice still sounding in the little office looked at his psychiatrist with a mixture of doubt, fear, and what might have been indignation on his face.

"You've been reading my mail," he repeated. "No one could learn that much about me from a bunch of stuff I said about some inkblots and some pictures I drew. I just don't believe it!"

"Nevertheless, there is the report. There are the facts which the psychologist has presented about you. And these are the things which you don't want to face about yourself, and yet you have just finished confirming them in my own mind as well."

The doctor took a long pull on his cigarette and looked directly into the face of the other man.

"But I didn't even tell him what I really saw." The patient was plainly puzzled. "I guess he must have gotten all this stuff from those tests, but I will never know how he does it."

And later when he was telling his buddies about it in the big room of the Alcoholic Rehabilitation Center, they said the same thing:

"How does he do it? That's the $64 question."

There is a name for the tests which were used to gain so much information about the patient. They are called "projective techniques." They are based on the principle that an individual will interpret any unstructured situation in terms of his own personality and needs.

"A Simple Projective Technique"

Let's take an example of an extremely simple projective technique. A big department store needs a man to handle the complaint department. They don't want an individual who will argue with the customers, and they don't want an individual who can't get along with people, and above all, they don't want an individual who can't keep his temper.

How do they go about finding such a man? In all probability they will simply hire a man who seems to the manager to possess these qualities and give him a try. Yet that man may, in his trial period, antagonize ten customers, among which is perhaps one who will never come in again, and who might have spent a great deal of money with the store. In other words, that man is potentially dangerous.

What could be done is this. First of all, all applicants would be screened by simple tests of appearance, poise, and intelligence by the receptionist who meets them as they apply. This would probably be done in any case.

Those who pass would be given an appointment for a definite time and told that they must be there at that time or they would not get the job. When they arrived at that time, they would be told the employment manager was out playing tennis and they would have to wait until he returned for their interview.

Some thirty minutes later, the manager would walk in through the front door. The receptionist would remark after he has gone into the office that that was the man. Some ten minutes would go by and then the prospective employee would be called into the office. An open magazine would lie on the desk, in addition to a lighted cigarette.

The manager would open the interview in a noncommittal way, but as time went on he would gradually become more and more critical about the prospective employee. He would find fault with his experience, his references, his clothes, and express little hope of the possibility of his getting the job. In addition, he might pay very little attention to the applicant and constantly glance at the magazine in front of him.

At the end of the interview, the manager would quite gloomily pass him back to the receptionist, perhaps with some remark about not wasting the company's time by applying for a job which he could obviously not fill and state that they could, however, let him know the next day if he got the job. Such a job interview would eliminate a lot of applicants in short order. Regardless of their needs, a lot of men would not have the patience to wait for a man who was playing tennis when he had an appointment.

Others would blow up in the office at the critical air of the manager, while others would not bother to see the receptionist at the end of the interview. There would be all kinds of responses to the situation, yet all of them would go through the same test procedure. A few would endure the conditions, showing good temper control and much patience in a situation where they might have been justified in expressing anger.

The Relation To Butner's Test

These are the men from whom the complaint department could be staffed with reasonable assurance that they would not cost the store many customers.

From this situation to the tests employed by the ARC psychology staff seems like a long jump. Yet there is really not so much difference between them. The major point is that the test employed by the department store was used to find ONE particular kind of person, while the tests employed by Butner are designed to show ALL the millions of different types of personalities in several different aspects.

Butner attempts to discover from these tests such things as the intelligence of the subject, his emotional control, his worries and how he handles them, the extent to which he makes excuses or to which he really knows himself, and how he gets along with other people, including his parents, wife, and children. Also, by giving one of the tests three times during his stay, we try to find out how much the immediate benefit of the alcoholic's stay has been.

The "battery" of tests employed for this purpose is carefully selected to give maximum information within the framework of the ARC's program. Four tests are included: The Rorschack "Inkblot" Test, The Draw-A-Person Tests (interpreted on the principles summarized by Karen Machover), The Otis Quick-Scoring Group Intelligence Test, and the Manson Evaluation.

"We have here a set of cards. Each one has inkblots on it. Look at each card and tell me what you see or anything that might be represented. You may look at the card as long as you like, but tell me everything you see.

ONE MORE LINK IN THE CHAIN

When you are through looking at a card, place it on the desk to indicate you have finished and we will go on to the next one."

In this way, the Butner psychologist introduces the Rorschach Inkblot Test to the patients. What the patient sees in the blots is more or less put there by his imagination. These reactions often give a glimpse into the workings of his personality, how he has handled and will handle new situations under various circumstances.

These responses often show the patient's sensitivity to conventional situations, his manner of logical or abstract or down-to-earth thinking, his emotional and intellectual concept of himself, his degree of self-confidence or immaturity, and many of his environmental or family or social pressures.

Recording Results For The Doctor—Major Job

After the patient has seen all the cards, and his responses recorded by the examiner, they are gone through again to clarify what was seen. That ends the test for the patient. The psychologist then begins the important job of recording the results for the doctor.

Many factors and patterns are involved—physical, intellectual, emotional interactions—the positive or negative ways a patient has made use of his potentialities. This personality picture often helps the doctor understand the patient. This understanding is used by both the doctor and the patient in helping the sufferer realize his emotional needs and personality problems and in helping him face old irritations with new maturity.

The drawing test, in which the patient draws a person, is used chiefly to get some ideas of the patient's present problems and the particular areas of difficulty in his relationship to both himself and other people. In attempting to make an analysis of the drawings, many factors must be considered by the psychologist.

Many Points Examined In Each Drawing

First, there is the overall appearance of the drawing. While we do not expect the subject to be an artist, much can be gained from examining the combined factors scored which cannot be gained from examining single points. Then we move on to consider such points as the placement and size of the drawings, the stance, the action, if any, taking place, the presence or absence of clothing, the type of line employed and the details of the person.

The Otis Test gives us an estimate of the intelligence of the patient. The Manson Evaluation shows the extent to which the patient conforms to other alcoholics on certain personality factors and the areas of major maladjustment.

We put all of this information together and compare the results of the various tests. From this, we write a well-rounded description of the personality involved as it appears to us in the tests.

This summary appears on the green sheets headed "Psychological Report." These reports form one more link in the chain composed of the psychological tests, the social history report, the doctor's impressions from the group discussions—one more link toward helping the doctor get to the heart of the patient's troubles in the private interview.

BOTH PHYSICAL AND EMOTIONAL

According to many physicians, 50 to 75 per cent of all people who go to the doctor have no organic disease. This is not to say, however, that those who consult a doctor, whether with or without organic disease, do not need help. They do! And the sufferer himself often cannot distinguish between definite organic disease and emotional disturbances.

The belief is held by some that if one's basic difficulty is emotional, the sufferer is responsible for his illness in some way that is different from that of an organic disease. This is not true. Not only do we now recognize that emotional disturbance is an illness, but that many things which have been ignored or misunderstood in the past respond to treatment, and must be treated if later trouble is to be avoided. One thinks immediately of grief as an emotional illness and a contributing factor to physical disturbance.

A pastor recently told me of meeting a surgeon friend who seemed very discouraged. When the pastor inquired of the doctor why he was so "down," the doctor said, "I just lost a patient." The minister said, "Well, you have lost other patients, haven't you?" "Yes." the doctor replied, "but this one was unnecessary. Shortly before the operation the patient was told that his wife had been killed in an accident. If I had known that he had received such news I would have postponed the operation." The minister asked, "You think the news of his wife's accident contributed to his death?" The doctor said, "I'm positive it did."

A girl was brought to an Eastern hospital for treatment and died within a short time. Following the autopsy, the attending physician said to the girl's mother, "We could find no cause of death at the autopsy examination." The mother replied, "Oh, doctor, you don't have to tell me why she died. She died of a broken heart. The young man to whom she was engaged was killed a few weeks ago. Since that time she has had no interest in anything. I'm not surprised she died. I would have been surprised if she had gotten well." (Incidentally, if you have a loved one who becomes ill and you have that type of information, be certain to report it to the attending physician. It is important information that he should have.)

Was that girl responsible for her death? Obviously not. She had no more control over her sense of loss, or "broken heart," than she would have had over a cancer that was destroying some vital organ of her body. A broken heart due to a grief experience can now be treated, usually successfully. That is, successful in the sense that the suffering can be relieved to the extent of enabling the person to resume life with a degree of happiness.

And so it is with any emotional disturbance which physicians now think of as illness. This illness needs treatment just as much as physical disease.

(Dr. Russell L. Dicks, editor of the new magazine, RELIGION AND HEALTH, Box 4802, Duke Station, Durham, N. C.)

"WHAT CAN I DO?"

A Lenoir County Teacher Asks

It was not that time was hanging heavy on my hands that made this question, "What can I do?", become such a dominant thought in my life; for teaching school and looking after my family were certainly enough to keep me busy. I really did not want anything to do, but something happened in my life which filled me with a great desire to serve in a field where I felt so much good could be done.

It was my privilege to make the acquaintance of a number of rehabilitated alcoholics, and the miracle I saw that had taken place in their lives, especially those who were members of Alcoholics Anonymous, caused something to happen inside of me. To behold an individual, who was so miserably unhappy and apparently only a burden to his family and society in general, become a happy, useful citizen was as miraculous to me as watching a caterpillar transform into a beautiful butterfly.

I wanted to know the secret of such a miracle, and the more I learned about the disease of alcoholism, the more I asked myself, "What can I do to help make this happiness possible for the great number who have not yet found it?" I knew well the stigma that was attached to the subject of alcohol, but from what I had observed, I realized the cause was worth any criticism my efforts might produce. As if in answer to this question, I happened to read in the newspaper that twenty scholarships were to be given to the Yale Summer School of Alcohol Studies by the N. C. Alcoholic Rehabilitation Program.

To The Yale Summer School And The Latest Alcohol Facts

I sat down that very night and sent in my application, for I felt in this way I could find the answer to "What can I do?" Then the next miracle happened in my life, for I was granted one of those scholarships which enabled me to enjoy four inspirational weeks absorbing all the information I might be able to use on my return.

How a person can serve in this field naturally varies with the community in which he lives and upon the individual himself, so as a result of my summer school work, I tried to decide what my possibilities were as well as my limitations. So before I discuss how I am trying to help, I would like to mention what I believe I cannot do or should not do, for to me that is equally important.

First of all, I firmly believe I cannot *make* any alcoholic stop drinking. Even though an alcoholic sincerely loves a person, he can stop drinking only for one reason, an honest desire to stop. This desire must stem from a purely selfish motive and not because someone else wants him to stop, or he will never successfully make that long hard pull. If I were an alcoholic myself, my chances of helping would be much greater, for there is nothing so inspiring to a suffering alcoholic than a happy, calm individual who in the past has suffered just as he is doing.

Furthermore, there is no advice I can give which will be effective, even if it is the same as that given by another alcoholic, because there is always

present that feeling of "you just don't understand." Realizing my limitation in this capacity, I regretfully leave that part of the work to the members of A.A. or those trained in rehabilitation work, and turn my efforts to less direct means.

In order to succeed even in this way, there is one thing I feel I should not do, and that is to be overbearing in my efforts. It is possible to be so enthusiastic in your desire to be of service that your every thought and topic of discussion are along that line. I know everyone else does not share my enthusiasm, and I can easily defeat my purpose if I become known as a "one-topic" individual. I make it my policy never to be the instigator of the subject but always contribute my share of the conversation whenever the opportunity arises.

Although being limited in my ability to help in rehabilitation, teaching gives me a wonderful opportunity to work from the prevention angle. Regardless of the grade or subject, every teacher can stress the importance of maturing emotionally, spiritually, and socially as well as mentally and physically so that our boys and girls will not feel the need of alcoholic beverages to help them face the responsibilities of adulthood. Emphasizing mental hygiene, I believe, is a much more positive way of teaching the subject of alcohol than the "scare method", or negative approach, which has been used largely in the past.

Always Helping—In The Home, The School, The Community

In addition to my teaching, I am trying to help:

The alcoholics—by creating a more understanding public; by trying to let them see someone is interested in working in their behalf; and by informing them where help can be obtained if they express a desire for help.

Those with a problem in their home—by helping them understand the nature of the disease and encouraging them to adopt a helpful attitude toward the alcoholic instead of an antagonizing one.

The schools—by furnishing teachers with the latest scientific information available regarding both the subject of alcohol and the methods of teaching it.

The community—by being willing to speak at P.T.A. meetings, social clubs, civic organizations, or to any group of interested persons; by arranging for a series of radio transcriptions on alcoholism and a month's library display of materials furnished by the N. C. Alcoholic Rehabilitation Program; and by encouraging a new attitude toward the alcohol problem that may someday lead to a community plan of action.

The wonderful part of this rehabilitation program is that each person in North Carolina may have a part in it if no more than adopting a sympathetic attitude toward its work. There is joy in serving those less fortunate than yourself even though you cannot measure the results any more than you can the effects of a happy smile. I challenge everyone to accept his responsibility in this program by seriously asking himself, "What can I do?"

Butner Center Vividly Portrayed

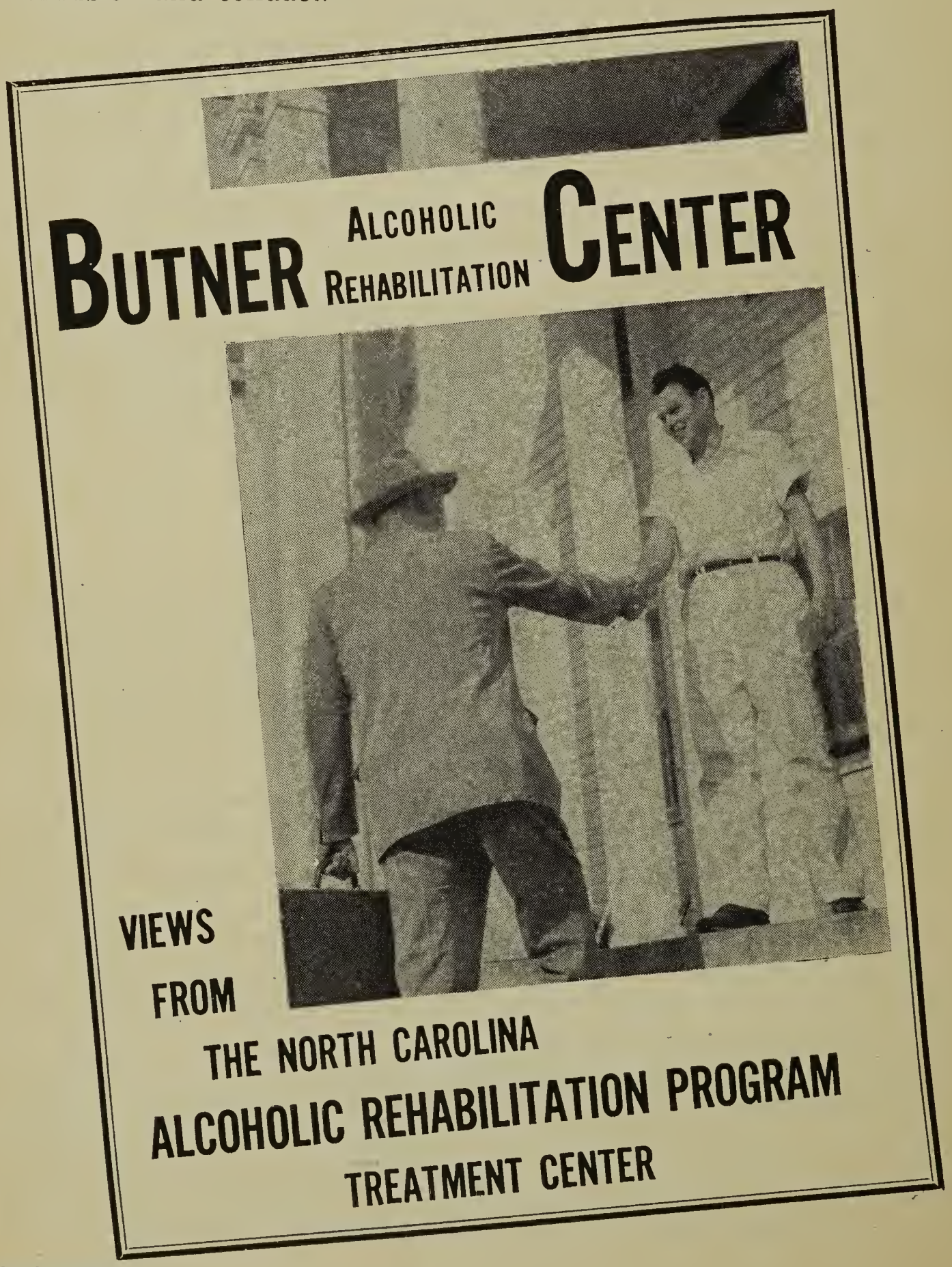
"Will he be mistreated?"

"What kind of food do they serve us? Is there any recreation?"

"Are they going to lock Joe up? What kind of treatment is it?"

These questions and many more like them are often asked about the Butner Alcoholic Rehabilitation Center.

In answer to many requests, a new Butner Brochure emphasizes the pioneer Center's philosophy of voluntary admissions and teamwork treatment and illustrates the group discussions, emotional health films, planned diets, private consultations, recreational activities, occupational therapy, and the rules for admission and conduct.



This brochure gives a representative picture of North Carolina's Alcoholic Rehabilitation Center at Butner. We hope it will answer many of the questions often asked about the Center.

DAVID A. YOUNG, M.D.
General Superintendent
N. C. Hospitals Board of Control

The Butner Center is the treatment division of our North Carolina Alcoholic Rehabilitation Program. We hope this booklet will encourage anyone who might need the treatment.

S. K. PROCTOR
Executive Director
North Carolina ARP

Between these pages, North Carolina citizens will find their state taking another progressive step toward understanding and treating that emotional sickness we now call alcoholism.

JOHN S. RUGGLES
Chairman, Alcoholic Committee
N. C. Hospitals Board of Control

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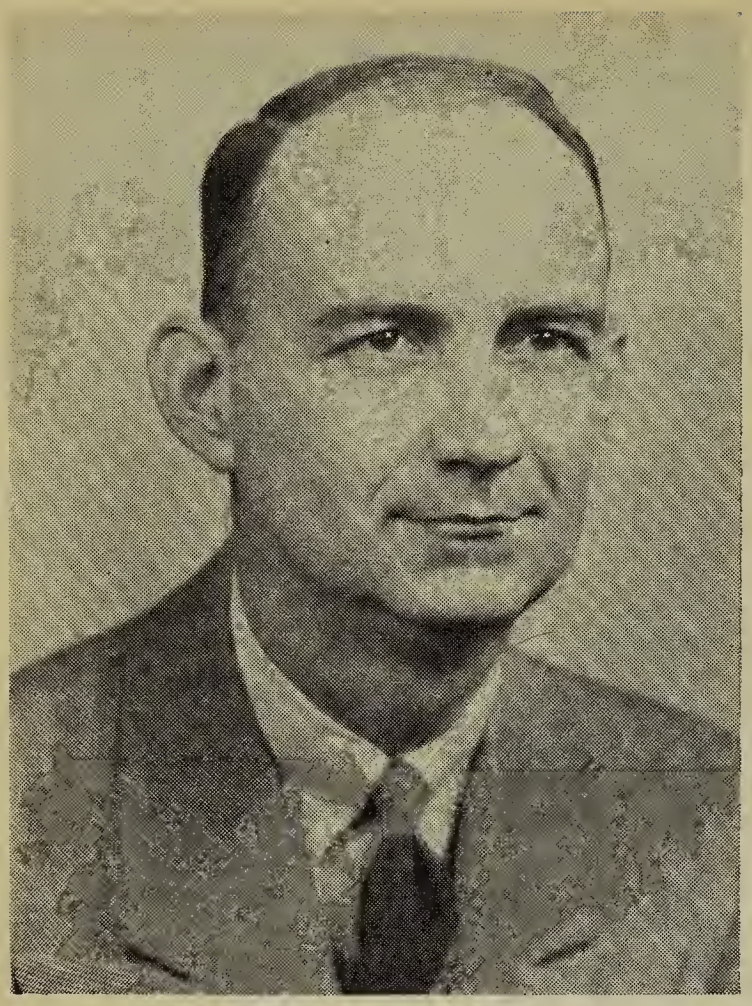
It views the Chaplain as a member of the healing team, attendants who keep the treatment wheels rolling, and social caseworker services. Further views include the psychological tests for determining personality needs, the social history outline for successful diagnosis and treatment, the ARP director's letters and questionnaires, and comments from both in-patients and out-patients. This brochure is another step in the ARP's information service to the general public and to those people professionally interested in alcoholic rehabilitation, education, and prevention. For free copies, write The ARP, Box 9118, Raleigh, N. C.



S. KINION PROCTOR

Under the leadership of S. K. Proctor, North Carolina's Alcoholic Rehabilitation Program has climbed to a top position among the nation's various commissions on alcoholism. Evidence is found in statements from rehabilitation authorities over the country:

"In time North Carolina will be a model for other states unfolding their own programs."

A professional administrator and strong advocate of the teamwork method of treatment and prevention, Proctor attended Duke and the University of North Carolina, engaged in private business before entering the Army in 1942, and came to the ARP from his position as assistant administrator of the City Memorial Hospital in Winston-Salem.

Since assuming directorship of the ARP, Proctor has attended Yale Summer School of Alcohol Studies, participated in regional and national meetings of state commissions on alcoholism, and has appeared before civic, professional, Alcoholics Anonymous, and radio audiences. He directs the over-all program from the ARP administrative office in Raleigh.

Summer Studies On

During the week of June 9-13, the Nor
will join the Extension Division of the Un
sponsoring a week of Summer Studies on

Under the joint administrative leadership
Division director, Russell Grumman, the Su
McCarthy, famed Yale authority on alcohol
in the field.

Designed for the general public, the Stud
interests bring them into contact with the
room, the church, the factory, the jail, the h

General matriculation information can be
N. C., or the Extension Division at Cha
$10.00, and dormitory rooms are $8.00 for t
fees, meals are available at private boarding

The Summer Studies will give a digested
the various fields of alcoholic problems. As
curriculum and the staff of lecturers repr
the social, medical, religious and educationa

Lecture

MONDA

9:00 A.M. Registration
10:00 A.M. Introduction and Orientation)-
10:30 A.M. Social Science Approach to So
2:00 P.M. Physiology of Alcohol)—Dr. L
3:15 P.M. Alcohol and Traffic)
Demonstration of Alcometer)
7:30 P.M. Film: "Alcohol and the Hum

TUESDA

9:00 A.M. The Psychological Effects of
10:15 A.M. The Nature and Extent of P
2:00 P.M. Theories in the Development
3:15 P.M. Systems of Legal Control)—
7:30 P.M. Films: "Preface to a Life" a

acts About Alcohol

Carolina Alcoholic Rehabilitation Program
sity of North Carolina at Chapel Hill in
; About Alcohol.

ARP director, S. K. Proctor, and Extension
er Studies will be directed by Raymond G.
s and problems and author of many books

will be open for all citizens whose work or
lems of alcoholism, whether in the school
ital, or the home.

ired through The ARP, Box 9118, Raleigh,
Hill. Registration and tuition fees total
week's session. Not included in the general
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t a balanced, teamwork approach toward
roblems of alcohol.

chedule

JUNE 9

octor, Grumman, McCarthy
Problems)—Dr. Lee M. Brooks
Greenberg
reenberg
Body")—Greenberg

JUNE 10

ohol)—McCarthy
lems of Alcohol)—McCarthy
Personality)—Dr. R. C. Proctor
C Institute of Government
"Over-dependency")—Dr. Lorant Forizs

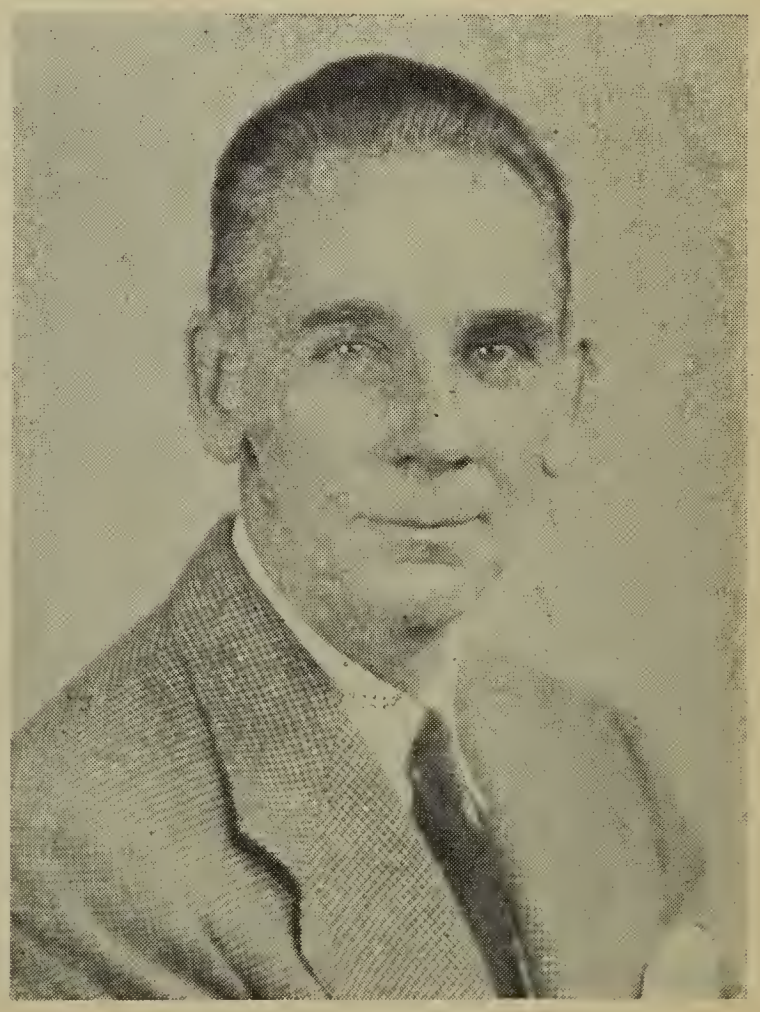
RUSSELL M. GRUMMAN

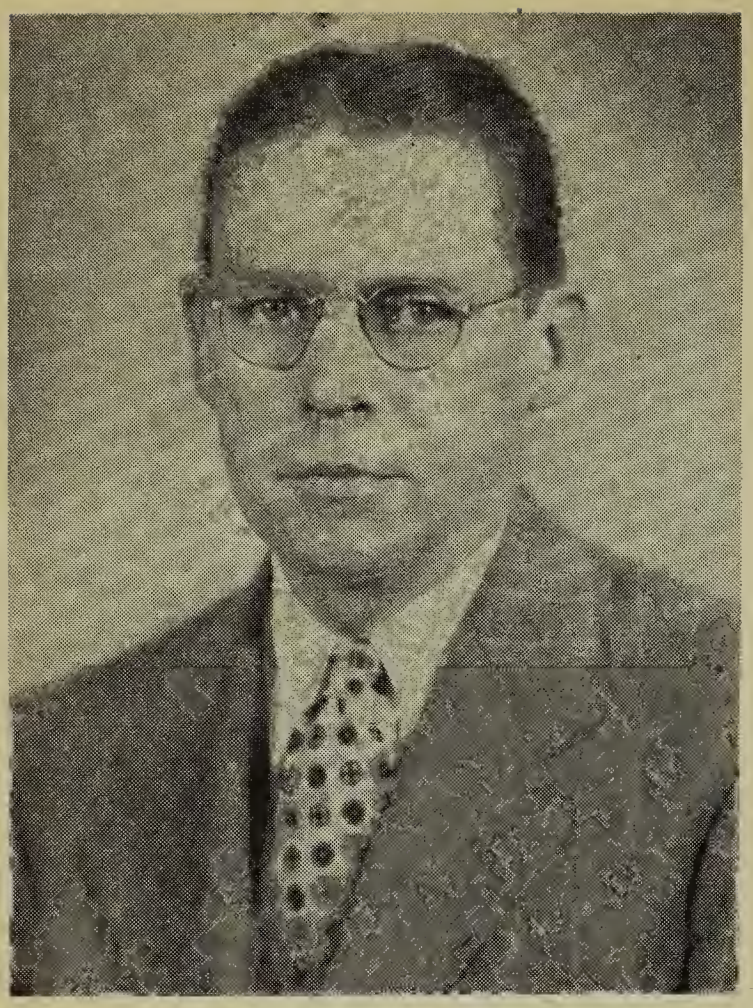
The Summer Studies will be under the co-sponsorship of Russell M. Grumman, director of the UNC Extension Division.

He will join Proctor and McCarthy in the orientation session at the opening of the Studies on Monday, June 9, and in a summation of the week's work on Friday afternoon, June 13. A special curriculum folder is being prepared through his office for distribution upon request.

Civic, educational and church leader, Grumman holds various committee positions with the N. C. Recreation Commission, the Boy Scouts Council, the state's Cerebral Palsy Hospital, Governor's Conference on Aging, Roanoke Island Historical Association, and N. C. Congress of Parents and Teachers.

In addition, he is a member of the Adult Education Association of America, past president of the National University Extension Association, secretary-treasurer for 10 years of the Southeastern Association for Adult Education, member national and state education associations, Chapel Hill Kiwanis Club, Methodist Church, American Legion, and N. C. Conference for Social Service.





RAYMOND G. McCARTHY

As executive director of the Yale Plan Clinic and director of educational activities for the Connecticut Commission on Alcoholism, Raymond G. McCarthy is nationally recognized for his grasp of alcohol problems. He brings to the directorship of the first North Carolina Studies on Alcohol much experience in lectures before Yale sessions and university, professional, lay groups in 22 states.

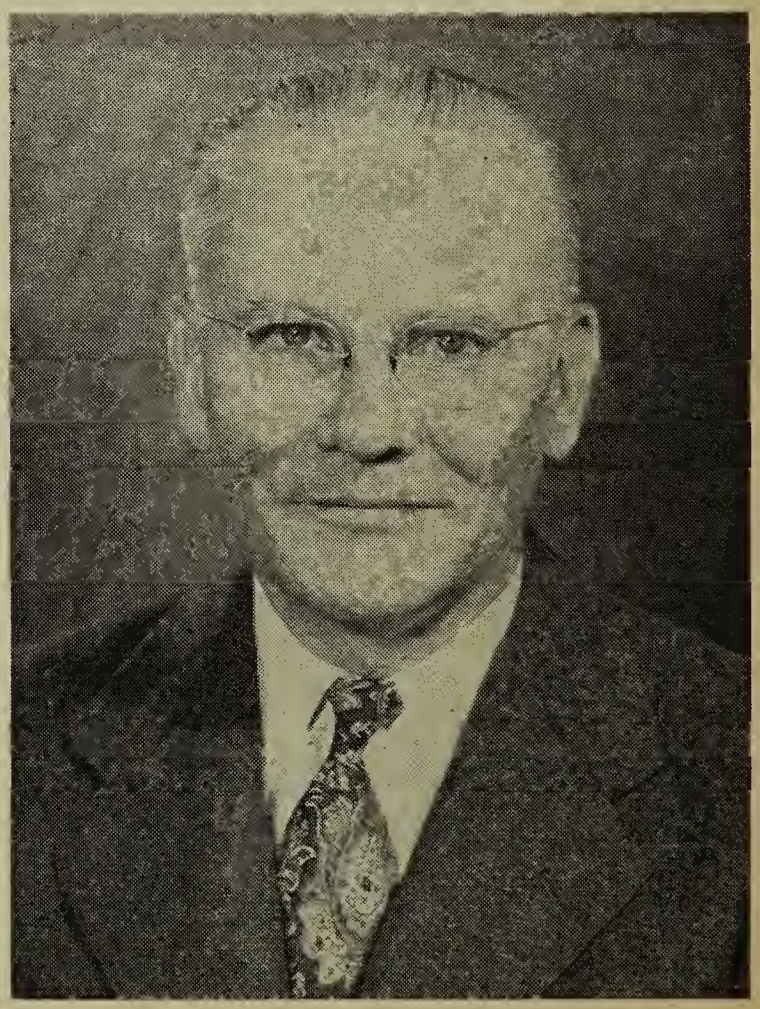
Contributor to the Yale Journal and co-author of **Alcohol and Social Responsibility,** McCarthy has conducted special projects for municipal and states agencies over the nation. He has served as consultant to Encyclopedia Britannica and Young America Films in their films on alcoholism and alcohol facts. His latest booklet, **Facts About Alcohol,** is an authoritative handbook for high school students.

WEDNESDAY

9:00 A.M. Alcoholism—Nature of the Problem)—McCarthy

10:15 A.M. Alcoholism and the Family)—Miss Beatrice H. Coe and Norbert Kelly

LEE M. BROOKS



As Professor of Sociology at the University of North Carolina, Lee M. Brooks is a specialist in the sociological fields of criminology, family, community, and social control. He will lecture on the Social Science Approach to Social Problems. His travels as a visiting professor and research scientist have carried him over the nation, into Canada, to Hawaii, and the British Isles.

Author of many books, manuals, and articles in scores of scholarly journals over the state and nation, Brooks has served as president of the Southern Sociological Society, secretary to the University's Division of Social Sciences, member of the N. C. Mental Hygiene Society Executive Committee, the American Sociological Society, and the American Association for the Advancement of Science.

LEON A. GREENBERG

As associate director of Yale's Laboratory of Applied Physiology and inventor of the famed Alcometer, Leon A. Greenberg conducts extensive scientific research in the fields of industrial toxicology and alcohol and lectures throughout the United States and in Europe. He will lecture on the Physiology of Alcohol and discuss the film, **Alcohol and the Human Body.**

Member of the Yale Journal's editorial board and the staff of Yale's Center on Alcohol Studies, Greenberg is now Associate Professor of Physiology and author of several books and publications on alcohol. Member of the National Safety Council's committee on tests for intoxication, he invented the Alcometer, foolproof tester for alcohol concentration in the body.

JUNE 11

2:00 P.M. The Church and the Problems of Alcohol (Historical and Current attitudes)—Dr. Olin T. Binkley
3:15 P.M. Instruction about Alcohol)—McCarthy
7:30 P.M. Alcoholics Anonymous)—Mr. X

OLIN T. BINKLEY

As director of the Department of Ethics and Sociology at the Southern Baptist Theological Seminary in Louisville, Ky., Olin T. Binkley is recognized nationally as a Christian scholar of everyday social problems. He will lecture on The Church and the Problems of Alcohol, picturing historical and current attitudes. He recently headed the Board of Managers of the Louisville Children's Agency.

Author of **The Churches and the Social Conscience** and other books, Binkley once directed the Wake Forest College Religion Department and instructed in sociology at UNC while pastor of the Chapel Hill Baptist Church. He is a Wake Forest, Louisville, and Yale graduate, a member of Phi Beta Kappa and the Social Service Commission of the Southern Baptist Convention.

RICHARD C. PROCTOR

As assistant director of Graylyn Hospital in Winston-Salem and director of its alcoholic clinic, Richard C. Proctor brings to the Summer Studies the experiences of a psychiatrist who diagnoses and treats sufferers of alcoholism daily. He will lecture on Theories in the Development of Personality. He currently instructs clinical psychiatry at Bowman Gray Medical School.

Member of the American Psychiatric Association and American Medical Association, Proctor graduated from Wake Forest and the Bowman Gray School of Medicine before rendering medical and psychiatric service in the U. S. Navy. In addition to his duties as psychiatric consultant for the VA and private agencies, he conducts a private practice of psychiatry in Winston-Salem.

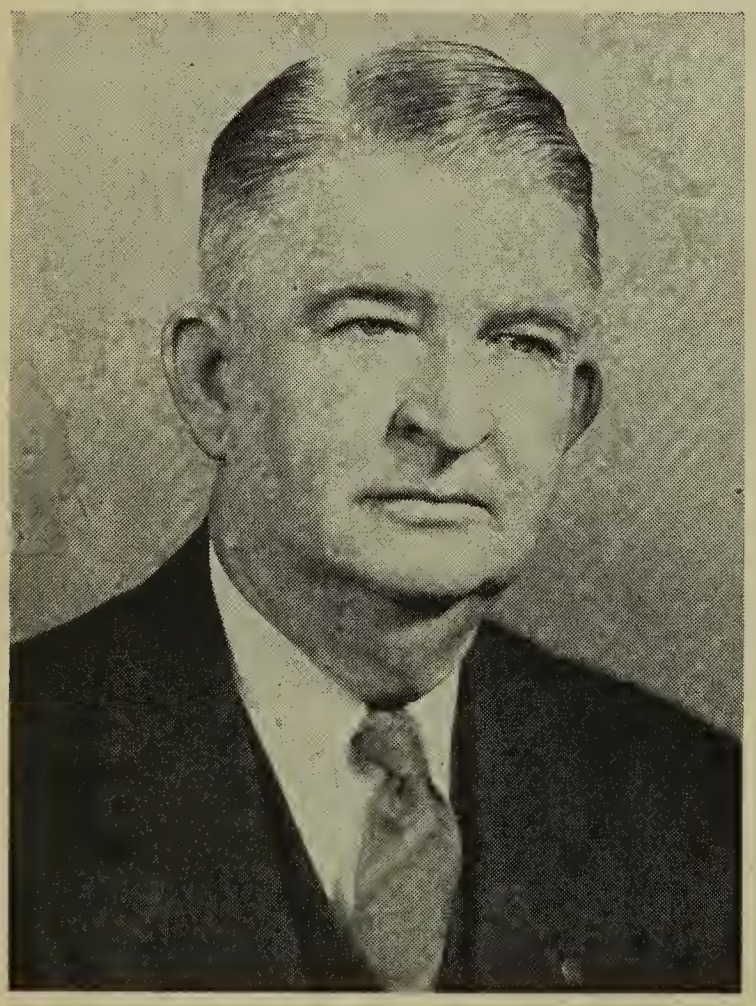
THURSDAY

9:00 A.M. Medical Treatment of Alcoholim)—Dr. Thomas T. Jones

10:00 A.M. The Dynamics and Psychiatric Treatment of Alcoholism)—Forizs

2:00 P.M. Seminars (two hours)

1. Educational—Leader: Mrs. Annie Ray Moore

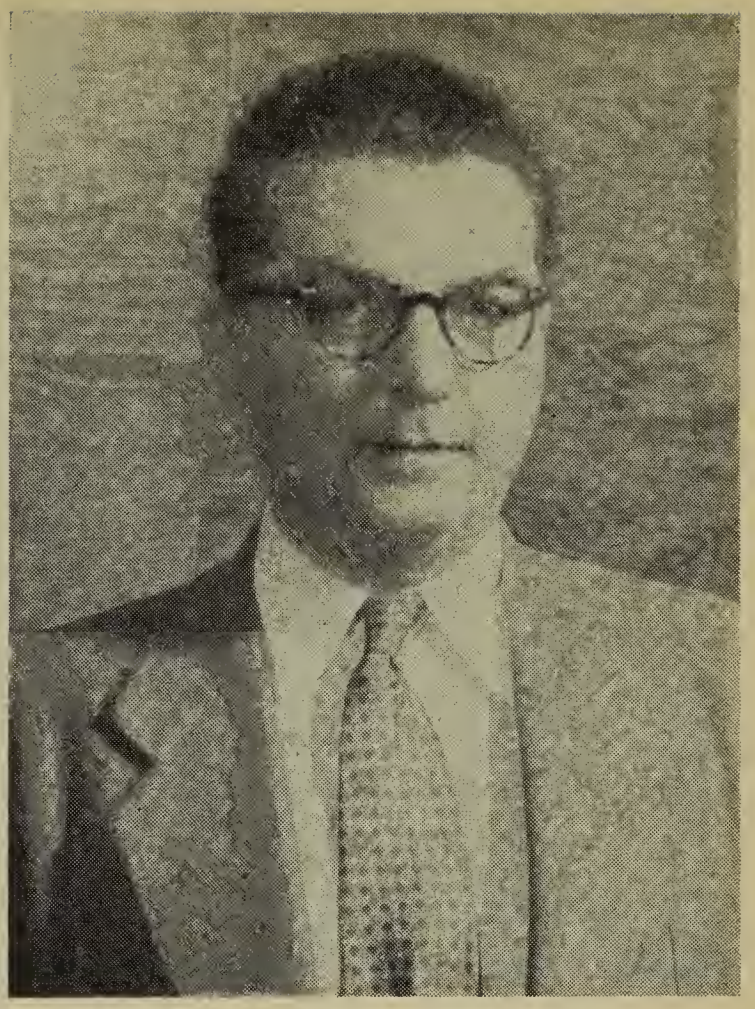


ALFRED R. WILSON

As judge of Durham County Recorder's Court and prominent Durham civic, church, and fraternal leader, Alfred R. Wilson is doing outstanding work in aiding alcoholic sufferers to return to normal, useful citizens. He will direct a seminar on Alcoholism, A Problem for Courts and Jails. He is chairman of a Butner Youth Center Project for North Carolina's first-offender boys.

Recipient of the Distinguished Award Key from N. C. Civitans and the Man of the Year Silver Loving Cup from Durham Civitans, Wilson is a prominent Methodist layman, a Wake Forest graduate, and a jurist well known for his rehabilitation of many problem drinkers who come before him. Welfare officials say his work with many offenders has saved the County thousands of dollars.

LORANT FORIZS



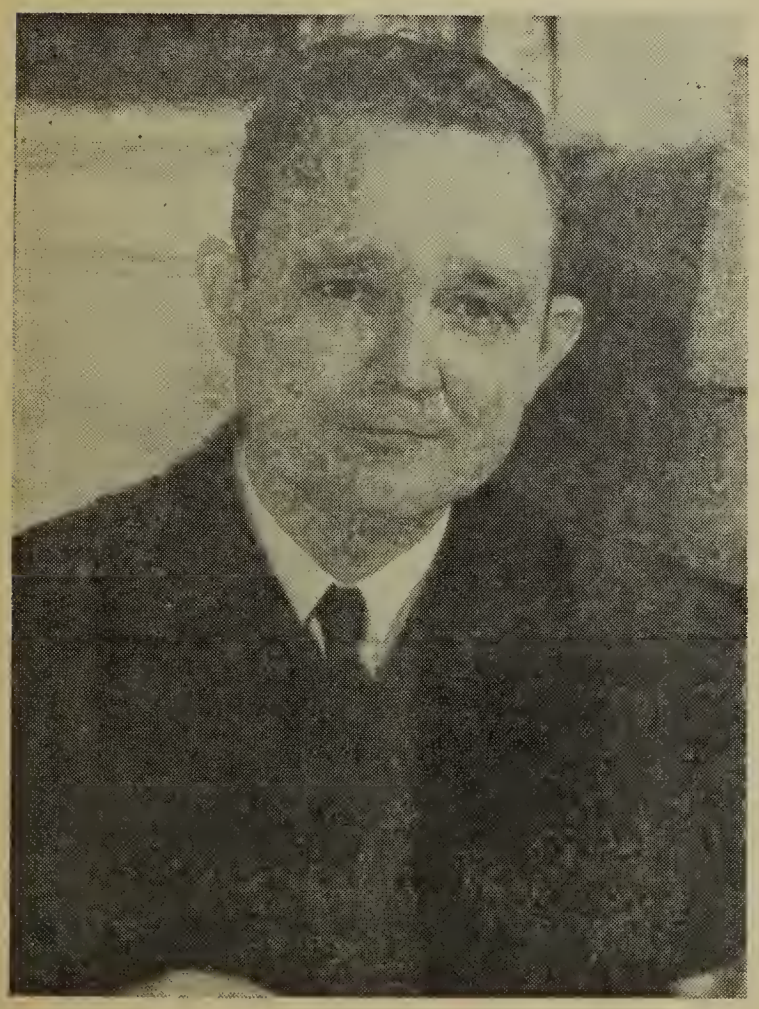
As medical director of the Butner Alcoholic Center and the ARP, Lorant Forizs has become known throughout North Carolina and rehabilitation circles over the nation for his successful method of teamwork treatment at the Center. He will lecture on The Dynamics and Psychiatric Treatment of Alcoholism and will discuss two treatment films, Preface to a Life and Overdependency.

Native of Hungary and graduate of the University of Budapest, Forizs was teaching at the university when the Nazis occupied the country. As the Russians invaded Hungary, he went to a displaced persons camp in Germany, and from there became psychiatric consultant to the Surgeon General of the U. S. Occupation Forces. He came to Butner through Dr. David Young.

JUNE 12

2. **Community Problems—**
   a. **Pastoral Counseling and the Alcoholic)—Rev. Leon Couch**
   b. **North Carolina ARP Progress**

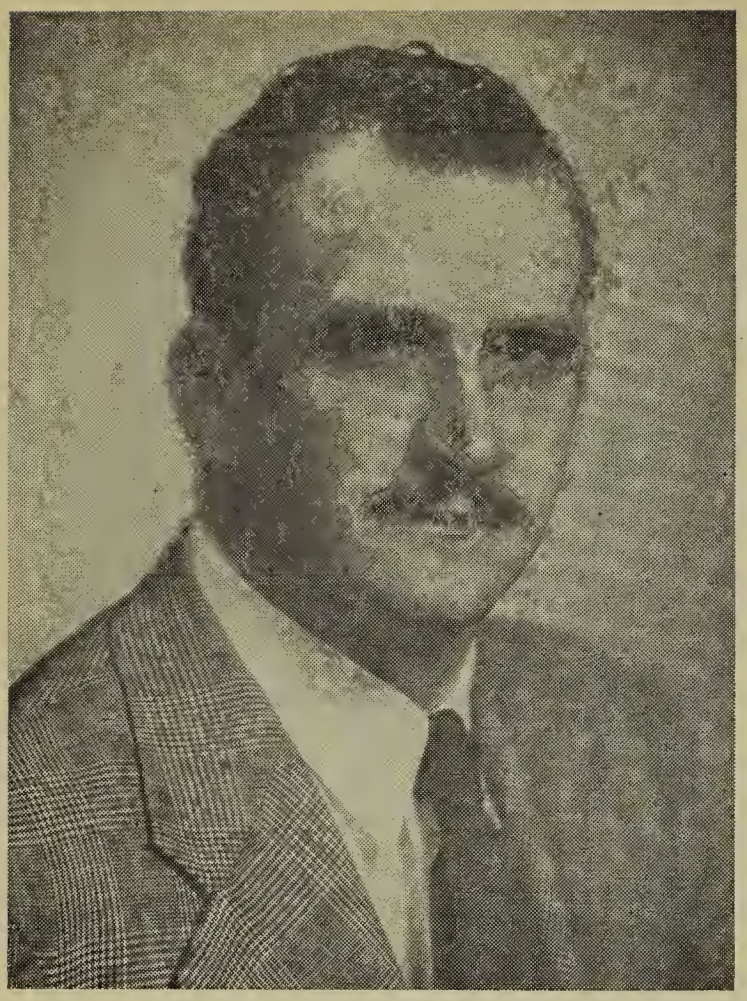
4:15 P.M. Film: "Alcoholism")—Before the entire student body



LEON COUCH

As a minister experienced with alcohol problems and conductor of alcoholism workshops in eleven southeastern cities, Leon Couch is widely known for his pastoral counseling of alcoholics. He will direct a seminar on Pastoral Counseling and the Alcoholic. Last spring he worked with Duke's Russell L. Dicks in nine alcoholic counseling clinics over western North Carolina.

Working closely with Alcoholics Anonymous, Couch has developed counseling insights highly successful with many sufferers. Graduate of Emory and Henry College and Duke's Graduate School of Arts and Sciences, he has studied at UNC, Harvard, and Columbia. He has attended Yale's Alcohol School, written on alcoholism, and has instructed in pastors' schools over the South.



PETER P. COOPER

As a professional educator and an accomplished public speaker on alcohol problems, Peter P. Cooper is director of an educational program unique in American history. Nearly two years ago he was given the job of creating the only ABC department of education on alcohol problems in the nation, the Rowan County program in Salisbury. He will conduct the seminar on Community Problems.

After graduating from Catawba College and UNC, Cooper attended the Yale Summer School of Alcohol Studies and did months of research before opening the pioneer program of education in Rowan. An outstanding leader in both curricula and extra-curricula work in college, Cooper is active in many civic movements currently under way in Salisbury and Rowan.

FRIDAY

9:00 A.M. Alcoholism—A Public Health Responsibility, survey of state and local activities, 1940-52)—McCarthy

10:00 A.M. North Carolina ARP)—Administrative, Proctor; Medical and Therapeutic, Forizs

2:00 P.M. Seminars

1. Education)—Mrs. Moore

MRS. ANNIE RAY MOORE

As a health educator for North Carolina's School Health Coordinating Service and former principal of elementary schools, Mrs. Annie Ray Moore is professionally acquainted with the needs and activities of health education in the public schools. She will direct a seminar on Education, planned for teachers interested in coordinating unbiased alcohol facts into their instruction.

Staff member of the UNC Health Education Workshop for four summers, Mrs. Moore is a graduate of Guilford College and the University of North Carolina's School of Public Health. She has attended Yale's School of Alcohol Studies. Representing the State Department of Public Instruction and State Board of Health, she promotes local health education projects among teachers.

MISS JANE LATHAM

As president of the North Carolina Association of Caseworkers and member of the executive board of the American Association of Social Workers, Miss Jane Latham is in touch with the problems of alcoholism on the community level where causes and results are most vividly revealed. She will direct a seminar on The Social Agency and the Problem of Alcoholism.

Currently associated with the Mecklenburg County Department of Public Welfare, Miss Latham graduated from Flora Macdonald College, worked in city recreation and taught school before entering social work in Duplin County. Graduate of Vanderbilt University Social Work School and member of Charlotte's Community Council of Social Agencies, she attended Yale's Alcohol Studies.

JUNE 13

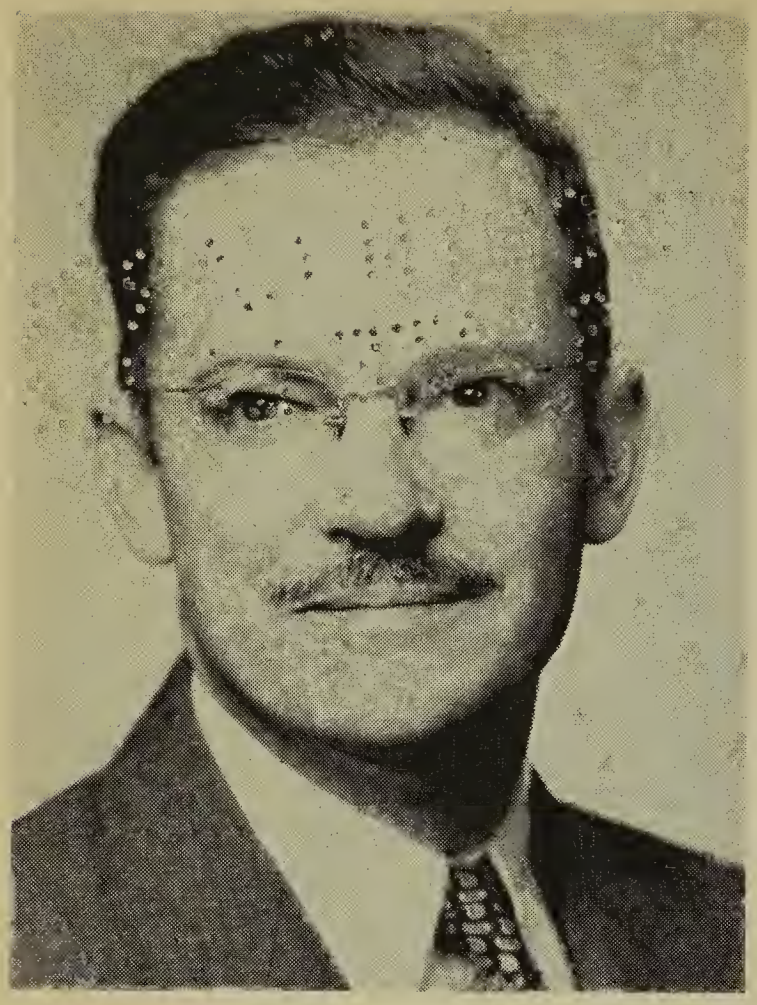
2. Community Problems)—Leader: Peter P. Cooper
a. Alcoholism—A Problem for Courts and Jails)—Judge A. R. Wilson
b. The Social Agency and the Problems of Alcoholism)—Miss Jane Latham
4:00 P.M. Summation)—Proctor, Grumman, McCarthy

ALCOHOLICS ANONYMOUS

"I need AA meetings like food. They're the same to my mental and emotional makeup as food is for my body." So spoke the Alcoholics Anonymous member who will interpret AA to the Summer Studies. Instrumental in the creation of the first AA state convention in '48, Mr. X spent sixteen years with a chain grocery, at one time their district supervisor, before or until . . .

Moving through yearly vacuums, job in and job out, he finally tapped his mother for a $1500 loan to open a business. After an $800 detour, six months on the streets, he discovered AA, struggled with its principles until he found their source. He is now a successful businessman, an AA for six years, and according to a fellow member, "One of the most sincere men you'll ever listen to."

Mr. X



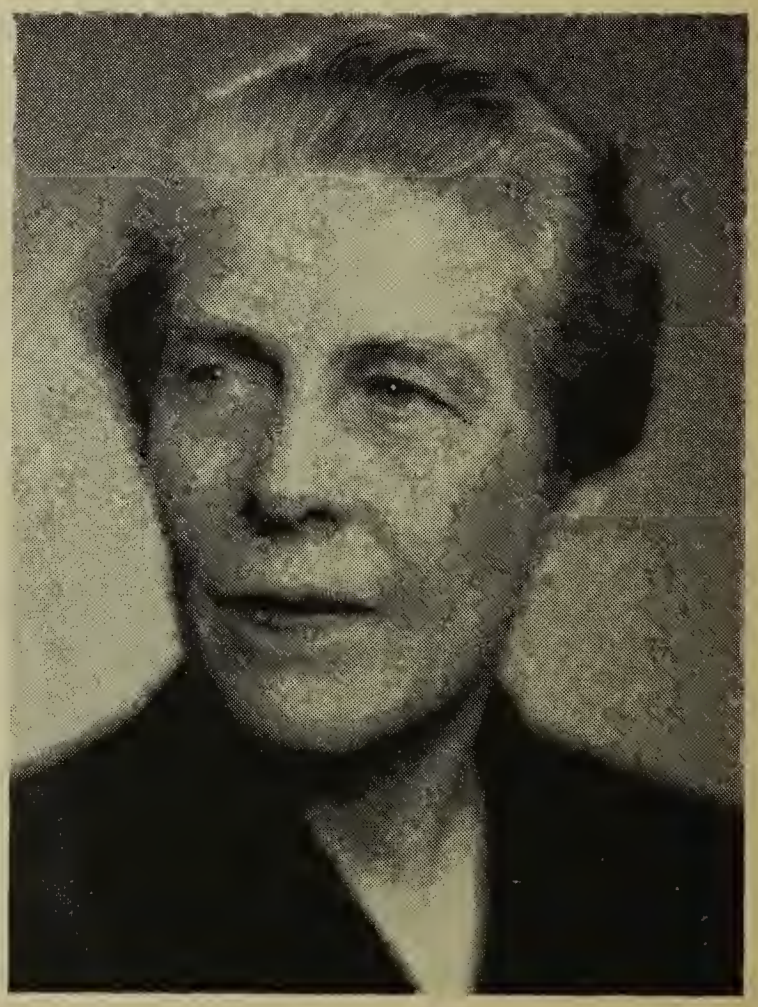
THOMAS T. JONES

As a private physician in the general practice of medicine for the past two decades, Thomas T. Jones of Durham has had practical experience in treating and aiding acute cases of alcoholism. He will lecture on The Medical Treatment of Alcoholism, including the role of the general practitioner. He is a staff member of the Duke, Watts, and Lincoln Hospitals in Durham.

A graduate of Davidson College and Johns Hopkins Medical School of Baltimore, Jones was in general practice in Durham for eight years before entering the Army in 1942 to serve with the 65th General Hospital Unit. He is a member of the Durham-Orange County, North Carolina and American Medical societies, and is an elder in the Presbyterian Church.

The purpose of the Summer Studies is to offer North Carolina citizens the latest facts relative to alcohol and the illness of alcoholism. It is hoped that many of the citizens who attended the Studies will return to their respective communities and use the information in presenting facts on alcoholism, from the pastor's study, the teacher's desk, the doctor's office, the health clinic, the caseworker's field, the Alcoholics Anonymous rostrum, and other public-service agencies.

MISS BEATRICE COE



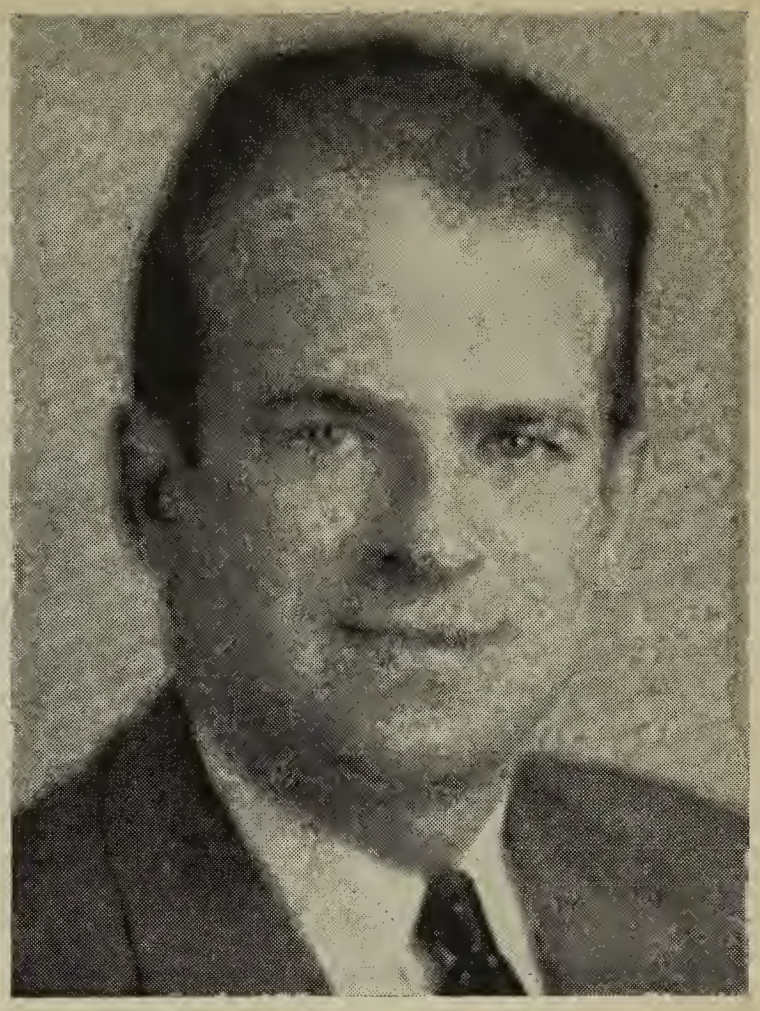
As a psychiatric social worker and staff member of Graylyn's alcoholic clinic in Winston-Salem, Miss Beatrice Coe is currently engaged in the Bowman Gray Medical School's graduate training program in psychiatry. She assists in the treatment of patients admitted to Graylyn, psychiatric hospital of the school. She will join Norbert Kelly in a lecture on Alcoholism and the Family.

Miss Coe was case supervisor for the Richmond Family Service Society, in consultative contact with the alcoholic clinic of the Medical College of Virginia, before coming to Bowman Gray. Graduate of Vassar College and Smith College School for Social Work and former member of the National Board of the Y.W.C.A., she has a wide background in teaching, group work and organization.

NORBERT L. KELLY

As a research fellow at the University of North Carolina and a former instructor of sociology, Norbert Kelly is a social scientist whose principal interests are social pathology and personality development as related to social and cultural factors. He will join Miss Beatrice Coe, experienced psychiatric social worker, in lecturing on Alcoholism and the Family.

A graduate of the Carnegie Institute of Technology, Kelly served as a business analyist with the United States Treasury Department before joing the U. S. Air Force in 1942. After the war, he secured a Master's degree from UNC, taught sociology at Ohio Wesleyan University for two years before joining the UNC Institute of Research in Social Science as a research fellow.



A VITAL MEMBER OF THE TEAM

Many questions are often directed to the Butner ARC's social worker, a vital member of the Center's healing team. When the patient arrives for admission, the social worker usually interviews him and any relatives who accompany him, explaining briefly the program and general facilities of the Butner Center.

Case work services are available throughout the 28-day treatment period. The interviews deal with current realities—one man doesn't have a job to return to; another patient is rejected by his wife; an older sufferer is misunderstood by his son; a young patient is a "stand-offish" person with obvious desires for social activity; a middle-aged man is disgusted with his job, a likely factor in his illness; another fellow has an alcoholic wife.

These are just some of the social problems which harass many of the Butner patients. The social worker often helps the situation through professional advice or refers the sufferer to his community agency best suited for the particular problem.

These services are not compulsory. The patient knows they are available, and he knows it is all right if he does not use them. Like Butner's treatment, social service interviews are voluntary, desire for them is compulsory.

From the BUTNER BROCHURE

"All Of Us Who Work With People Are Constantly Faced With This Problem"

By Reverend Harry C. Hubbard
A Baptist Minister

Not every alcoholic is the man you see weaving uncertainly down Main Street on Saturday night, headed for his own "lost weekend." An alcoholic may be the individual who drinks himself quietly, secretly, desperately into oblivion—seldom or perhaps never betraying himself in public. Unfortunately there are many cases where only the closest friends or members of the family know of this disease. An official of the United States Health Service this summer, lecturing at the Yale School of Alcohol Studies, stated that alcoholism was one of the nation's four major health problems.

Perhaps the alcoholic is the man his family never talks much about—the father whose lurching entrance can fill a room with silent, agonized embarrassment or terror, or nervous laughter. Maybe he is the drinker who waits in remorse and wretchedness until the street is empty and the house is dark before going home.

An Illness Involving More Than The Sufferer

The victim of alcoholism does not limit himself to making his family unhappy, for he is invariably in trouble elsewhere. He falls down on his business and professional responsibilities. He is an all too familiar figure in the courts, jails, hospitals, and welfare offices. For every one of the 3,000,000 directly afflicted, it is possible to add one, two, or more whose lives have been tragically affected by the illness.

With the social pressures from society and with so many people trying to find an escape from the realities of life, the number of alcoholics is steadily climbing. Unfortunately this illness is no respecter of persons, class, social prestige, or physical condition. All of us who work with people are constantly faced with this ageless problem—what must we do with John Doe, who is capable but has now let alcohol get the best of him?

I remember so well a very painful example in my pastorate some years ago. The husband was a man who held a responsible position teaching Military Science in a preparatory school for boys. He was

paid a good salary, owned a comfortable home, had two fine daughters and a wife who was a very devout Christian woman. Time after time she would break down in tears when asked about some bruise or black eye and would tell of the harrowing experiences of the night before because her husband had experienced a "lost week-end." He was the type of individual who just could not be reached.

When sober, he did an exceptionally fine job, was a liberal man, and was kind to his family; but when drunk, he was just the opposite. I had left the pastorate and was in the Navy when I received a letter at sea telling of the very genuine religious experience that had come to this alcoholic, and how happy the whole community was because of this. After eight years, this religious experience is still a real part of his life, and he is one of the most active men in the church today. Here we have an example of the contribution that religion can make in the life of anyone.

Another case history is that of a young man who did some drinking while in the Service. While he was being examined for release from the Air Force, his tuberculosis was discovered, and he was sent to a hospital for treatment. While a patient in the hospital, occasionally he went out on passes and did some drinking.

Up to this point his drinking was not compulsive. Finally he was discharged from the hospital with an arrested case of tuberculosis. When he returned to his home community, his alcoholism became more pronounced, and he developed into a full-fledged alcoholic.

Fortunately, through the influence of friends, he came in contact with Alcoholics Anonymous, entered a university but his tuberculosis became reactivated, and now he is back in the hospital. Through the program of Alcoholics Anonymous, religion has become a reality to him, and with the combination of a spiritual experience and Alcoholics Anonymous, he should remain an arrested alcoholic, and I am hoping the same will be true of his tuberculosis.

There comes to my mind another case in which, so far as I know, the end was not as happy as the above two. One night at 10:35, during a cold, driving rain I received a call from a hospital that a new patient had been admitted who wanted to see a minister immediately. I asked if he had been placed on the Critically Ill list, and the nurse stated, "No." I asked if he were under the influence of alcohol, and she stated that she did not think so. I left a radio program in which I was particularly interested because it was the first

address by the President after the MacArthur incident and drove the eight miles in a pouring rain, wondering what type of patient I would meet.

When I arrived and introduced myself, it was quite evident that this patient was tremendously disturbed emotionally, and that this condition was aggravated by alcohol. I sat down and for two hours tried to be a patient listener. He freely admitted his alcoholism but was unwilling to face the realities of life and to accept the responsibility for doing anything about his condition. During his drying out period, he walked out of the hospital one night never to return. I do not know what happened, and yet I cannot help but feel that he became another occupant on some skid row.

Realizing that alcoholism is a continuing, progressive illness of the entire personality, we recognize that there is no sure cure that will work with all cases. More and more we are saying that we have an arrested alcoholic rather than a cured alcoholic. Surely no minister or doctor or psychiatrist would dare claim that he had the sure cure.

Some Approaches Any Minister Might Follow

From my past experience as a Navy Chaplain and a minister in the church, I would not dare claim a sure cure. From my study and experience, however, I would suggest some approaches that any minister might follow as he faces this particular problem in his own parish:

1. Learn the art of being a patient listener, never showing signs of shock by facial or verbal expressions.
2. Where the patient or parishioner has expressed confidence in you, by no means ever betray this confidence.
3. As far as possible make yourself available at any hour that the alcoholic might need you. Assure and reassure him of the fact that you want to be called whenever he needs you.
4. Never pour "preachments" upon the alcoholic. Try not to condemn him, and as you express your manly sympathy, offer a program of spiritual therapy in which the church becomes his ally rather than the institution which condemns him. As Thomas Chalmers, in a sermon entitled "The Expulsive Power of a New Affection," pointed out that as new-born Christians we must transfer our affection from worldly cares and lose ourselves in the service of our fellow men, so the arrested alcoholic in his revitalizing Christian experience must be taught to love his church and his fellow men. As he loses himself in their service, he needs to be kept active in the program of the church.

Here the minister can do much in seeing to it that he is kept busy and is accepted.

5. Every minister should constantly make reference to the local Alcoholics Anonymous chapters. Alcoholics Anonymous can be a definite ally of the church and can help many an alcoholic to keep this new life that he has found in the church.

6. In North Carolina we are fortunate in having an Alcoholic Rehabilitation Center at Butner, operated by our North Carolina Alcoholic Rehabilitation Program. Ministers who are not familiar with this program should acquaint themselves with it and should see to it that the alcoholic knows about the plan. It would be a splendid project for a Men's Group in the church to spend, say, a hundred dollars on an alcoholic as they provide his transportation and expenses for the 28-day treatment there.

In all this thinking and work that we do in the field of alcohol, we have to recognize the fact that there will be successes and there will be failures, and that we need to rely on Him who is our source of strength in dealing with these sick fellow men.

FUTURE FARE

In May, INVENTORY will observe anniversary number one by offering:

Operation Restoration: A Dual Portrait of Teamwork—An illustrated digest of ARP progress generally and of Alcoholics Anonymous life particularly. From the North Carolina scene, INVENTORY presents AA principles, traditions, experiences anonymously portrayed by men and women who know whereof they speak.

Alcoholism Research and North Carolina Industry—A general discussion of industry's interest in the alcoholism problem as revealed by contacts with 33 industrial plants, compiled for INVENTORY by Welton J. McDonald, Research Assistant, Institute for Research in Social Science, Chapel Hill.

The Alcoholic in the Minister's Study—A prominent North Carolina minister describes his approach to the alcoholic sufferer. Written for INVENTORY by Dr. Julian Lake, First Presbyterian Church of Winston-Salem, the feature includes some real-life experiences out of Dr. Lake's own study, facts carefully clothed in anonymity.

The Story Behind A Film—An enlightening account of why the new, highly regarded film, *Alcoholism,* was made by the Encyclopaedia Britannica Films, Inc., of what it shows, and of how and where it was made. Authenticity is the keynote of this realistic, honest portrayal of alcoholism.

Win Friends And Influence Patients

That alcoholics are sick people who need medical treatment seems now to be more widely accepted than ever before. In recent years many special clinics have been set up to give out-patient services to alcoholics, and treatment and rehabilitation programs have been tried out in jails, state farms and mental hospitals. One type of institution, however, which is more directly concerned with the care of the sick, has been relatively slow to find its role in the treatment of alcoholics. This is the general hospital. But there are many signs that general hospitals, too, are beginning to take part in the new program for alcoholics.

One of the outstanding problems in alcoholism arises from the fact that the alcoholic repeatedly gets drunk and needs medical care for the acute illness of intoxication. A person ill from any other form of intoxication—mushroom poisoning, insulin poisoning or iodine poisoning, to cite examples—is admitted to a hospital without any question that he belongs there. But a person ill with alcohol poisoning, commonly called "being drunk," has usually been denied admission in most hospitals. M. Hinenberg (Jewish Hospital, Brooklyn, N. Y.), has pointed out that until a few years ago there were hardly any hospitals in this country which would admit an acutely intoxicated alcoholic although he might need medical assistance just as much as some other patient having "a more fortunate illness."

In a review of institutional facilities for the treatment of alcoholism throughout the United States, E. H. L. Corwin and E. V. Cunningham (New York Academy of Medicine) found that hospital beds for this condition were "scanty and inadequate" and that those which did exist were not being used to best advantage. Most general hospitals would not admit "drunks." The only place where an alcoholic ill with acute intoxication could be sure of admission in the majority of American communities was the jail, and few jails provided a medical examination, not to speak of treatment.

According to S. L. Friedman (Mt. Sinai Hospital, Cleveland) this state of affairs was due partly to the conflict within American society in attitude toward drinking. On the other hand the drinking of alcoholic beverages is approved to the point that there is praise for the man "who can hold his liquor"; on the other hand there is only scorn for the man whose drinking becomes a problem. Another factor mentioned as partly responsible for this condition is the medical tradition which erected "artificial barriers between what is medical and what is social." This tradition made it possible for medical services and institutions to ignore the illness of a type of patient whose behavior aroused social disapproval. Alcoholism, marked by repeated drunkenness and other offensive actions, is just such an illness, and hospitals were in harmony with all of society when they rejected the alcoholic.

In line with the growing recognition of alcoholism as an illness, many general hospitals in recent years have provided beds for alcoholics. This new policy has demonstrated that the alcoholic is a suitable patient for the general hospital and benefits from treatment. And not only does he recover from his acute illness but the stay in the general hospital helps to alleviate the fundamental illness of alcoholism itself. This fact has been reported by a number of hospital administrators who have experimented successfully with services for alcoholics. Thus, L. C. French of the Knickerbocker Hospital

(New York City), 4 years after the opening of an 18-bed pavilion for alcoholics, offered the following evaluation of the results: The care of the alcoholic patients did not interfere with other hospital services; the alcoholic ward did not constitute a great nursing problem; the service was less expensive to run than a comparable surgical or medical service. The alcoholic ward was easily integrated with the regular medical services for teaching purposes. The service was regarded as highly worth while because of the great number of patients who went on, after discharge, to complete rehabilitation through measures begun while they were in the hospital.

A similar enthusiastic description of an alcoholic service integrated with a general hospital has been provided by J. P. Lee, business manager of the C. Dudley Saul Clinic, an 18-bed alcoholic service attached to the St. Luke's and Children's Medical Center in Philadelphia. Lee pointed out that the income of such a clinic for alcoholics "is adequate to cover normal operating expenses and provide good professional and nursing care."

By way of illustrating the requirements of such a hospital service, Lee outlines the routine procedure employed at the C. Dudley Saul Clinic as follows: (1) A medical examination on admission and just prior to discharge. (2) Routine laboratory tests, as well as special tests whenever indicated. (3) Intravenous infusion of glucose in saline with insulin and vitamins; minimal sedation. (4) Daily group therapy sessions, constituting the essential feature of treatment. (5) An individual interview just before discharge to help in formulating directives for the future. (6) An open forum once a week for the families of the patients, to create an understanding atmosphere at home. (7) Cooperation with local Alcoholics Anonymous groups, which take the patient over after discharge from the hospital. (8) A follow-up service.

Among the cities in which general hospitals have made beds available to alcoholics in recent years are Florence, S. C., New Orleans, La., Santa Barbara, Calif., and Seattle, Wash. Should the spread of this practice continue until general hospitals will admit alcoholic patients on the same basis as patients with any other illness, the task of those who are specializing in the treatment of alcoholism will be greatly eased.

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A Management Problem—Too

. . . More than a year ago I spent an evening with a group of company heads. One of them began to talk about his sales manager, who was engaged in drinking himself out of a job and a home. Within an hour every man in the group told of similar experiences he was having or had had with men of promise and achievement whose great weakness was that they could not take alcohol or leave it alone.

Since that time I have talked with a great many executives. I have found that almost all of them, too, have the same problem in their own companies. *I doubt if any of us, except those who have made a deep study of alcohol and business, realize to what an extent this problem spreads through all business.*

What bothers me is that so many executives do not or cannot see that *this is not as much a personal problem of the man who is losing his fight with alcohol as it is a management problem.* I am surprised that so many business men have so little understanding of or interest in modern medical and psychological findings about the causes of alcoholism. I am appalled at the number of business heads who encourage junior executives to be what is called "good entertainers" and then have no compunction about casting aside the alcoholic when he becomes a problem instead of an asset.

Some executives approach the problem by nagging the alcoholic, which, of course, is the surest method of driving him to the fancied consolations of drink. Others ignore the problem, saying, "John is a good guy. He'll work himself out of it." Others look at the problem as simply one of a desperate craving on the part of the alcoholic which has its roots in some mysterious twist of metabolism that has no relation to a man's childhood frustrations, his home problems or his fear of business failure.

I have found, on the other hand, a small minority of executives, particularly in larger companies, who have gone at the problem in the right way. They have hired trained medical men to work with alcoholics. I have found a few others who go out of their way to cooperate with that great organization, Alcoholics Anonymous. In some cases these are men whose own careers have been saved by A.A.

The first approach to the problem is, of course, to have an understanding of the alcoholic and his background. With that understanding, which can only come after a little tactful, persistent probing, comes sympathy. And with sympathy comes the first stage to reclamation.

Too few executives understand that with very few exceptions the alcoholic cannot save himself by himself. That is the basis on which Alcoholics Anonymous work.

Let's recognize the tremendous tax alcoholism levies on business. Then let us get an appreciation of its causes. Then let us cease to treat the alcoholic as a kind of stubborn, wayward outcast. And if we are the head of a small company, and cannot afford to hire the best medical help, let us put the alcoholic in touch with the best medical advice or with the nearest member of Alcoholics Anonymous.

(C. B. Larrabee, president and publisher, *Printers' Ink* Publishing co., Inc., 205 East 42nd Street, New York, N. Y.)

A R P Offers Scholarships To Yale Summer School Of Alcohol Studies

Twenty ARP scholarships to the 1952 Yale University Summer School of Alcohol Studies are now available to North Carolina teachers, public health and social workers, ministers, physicians, personnel workers, law enforcement officials, Salvation Army workers, members of Alcoholics Anonymous, and any citizen interested in the problem of alcoholism and the latest approaches to those problems.

The educational grants this year will include tuition, room and board. Sunday meals and travel expenses are not included.

Called "one of the most unusual courses in the history of American education" by a national news magazine, the Summer School runs this year from July 7 to August 1 and presents a broad orientation on alcohol and the many problems related to its use in society.

Applications for the special scholarships must be submitted to the ARP by April 27 and should include a statement of professional background and any particular interest in facts and problems relative to alcohol and the illness of alcoholism. The grants are for people desiring to advance alcoholic rehabilitation and alcohol education in North Carolina.

The curriculum features a broadly oriented background in the biology, psychology, sociology and history of the phenomena of alcohol beverages prior to the consideration of specific problems or programs. Another major emphasis of the Yale School is a disciplined approach to an understanding of the phenomena and problems being studied whether the particular method be scientific, legal, ethical, or administrative.

The tenth Yale session will differ somewhat from previous Schools in that the number of general lecture sessions will be reduced to allow more time for seminar and special interest meetings. In addition to the Yale Center staff, lecturers and seminar leaders are drawn from the University, other universities, and from non-academic agencies concerned and experienced with problems related to alcohol beverages.

Over 1200 students from over the nation, 100 from nine of the ten Canadian provinces, and fifteen representatives from ten foreign countries have attended the first nine sessions. In recent years, educators have formed the largest single category of students, followed closely by those working in therapy and public health and by those in the ministry.

During the past nine years, 56 North Carolina citizens have attended the Yale sessions, bringing Tar Heel representation to sixth place on the roster of 47 states, nine Canadian provinces, and ten foreign countries. Send applications to S. K. Proctor, The ARP, Box 9118, Raleigh, N. C.

INVENTORY

If we are to understand the illness of alcoholism, we must take an inventory of what we know and don't know about beverage alcohol and human personality.

If we are to solve the problems of alcohol, we must identify ourselves with the illness of alcoholism. Major and *curable* maladies of today were considered incurable for years, until society chose to tackle them rather than avoid them.

Such identification takes teamwork. It takes the hospital and its physician, the church and its minister, Alcoholics Anonymous and its experience, the family and its newspaper, the public school and its teacher, the radio and its public forums, the health, welfare departments and their trained case workers.

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